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FREUD AMONGST US*

BY PAUL FEDERN, M. D.

Any dedication of a statue or other memorial satisfies the personal feeling of love for, and gratitude to, the dead person. Usually the dead are really pitiable—they are soon forgotten, and are rarely mentioned by friends or opponents. We all constantly use and enjoy the fruits of their labors without thinking of the geniuses who have devoted their lives to gain them. Many of these men while living were despised or ignored, or even persecuted because of their works. Our forefathers reacted against them as we try not to react. Posterity should bestow even more honor to the dead, but also be ashamed of the futility of such honor after the death of the great. This dedication of Freud's statue should remind us all to render justice to the living who do original work.

The German-Austrian scientists, and, particularly, the faculty of the University of Vienna refused to recognize Freud; he never obtained the clinical position he needed and deserved. If Freud had died young, as did other great discoverers, he would have suffered the tragic experience of the rejected genius. Because Freud lived over 80 years, he himself experienced the satisfaction of the spread of his work and fame over the world.

At his seventieth birthday when we—Ferenczi, Jones, Sachs, Storffer, Eitingon, K. Pichler and myself—gave him the two volumes dedicated to his septuagenary, he was still very uncertain of the permanence of his work. He warned us not to deceive ourselves. He remarked that psychiatrists were becoming accustomed to give recognition to his name while they combatted psychoanalysis. Ten years later, at his eightieth birthday, the victory of his work could not be doubted. Yet, enormous patience and consistent application were necessary in order to resist the long period of opposition and stupid criticism, neglect and slander.

For us who knew the young and healthy Freud, this statue is sad and pathetic. The statue represents Freud as an old man, with the impress of constant strain and striving. Humor, charm and

*Tribute at the dedication of the statue of Freud at the New York Psychoanalytic Institute, November 12, 1947.

affability were strained by the fight against age, disease and pain. Yet his face retained the expression of strength, of kindness, clarity and truthfulness. We see him resting but undefeated; there was no fatigue or defeat in his whole personality.

Freud is the representative of all heroic fighters who advanced a truth which contemporaries were unable to accept and even to understand. This very opposition became another objective of his studies. Every great man must overcome three kinds of difficulties: first, the resistances in himself; second, the friction and fight with his contemporaries; and third, the difficulties arising from his work itself.

Freud was not only the first psychoanalyst, but he was also the first person to be psychoanalyzed. He analyzed himself. His book, *The Interpretation of Dreams,* contains a good deal of his self-analysis. This procedure gave him the knowledge of his own resistances and also the method of overcoming them. His self-analysis convinced him of the validity of his discoveries. During such studies he himself made all possible objections; they were the same resistances which he later met in his patients and pupils.

Quite a few of his followers deserted him. Once I was indignant about the ingratitude of one of these deserters. Freud explained it with psychological argument. He was immunized against being deeply grieved by any betrayal—through his early experience with Breuer, which itself was no betrayal, of course. The discoverer of "repression" and the initiator of the therapy of the neuroses, Breuer deserted his own work. Breuer could not tolerate the results of the method he himself had promoted.

The United States was the first country to acknowledge Freud as the outstanding discoverer and innovator in psychiatry. Stanley Hall and James Putnam were his first sponsors when Freud came to this country to receive the honorary degree of Doctor of Law at Clark University. Since then, Americans have accepted Freud's work with increasing interest. Books and papers are still filled with Freudian problems, findings and advices. Much of this is superficial, much is well understood and clearly written. Americans have become interested in psychoanalysis. It appears to me that this success was due to the ingrained American willingness to give everyone a fair hearing. The principle of free speech

and press has exerted its educating influence. And when psychoanalysis received the opportunity to prove itself, the merits of a daring scientific discovery and the fascinating style of a modest and sincere writer won general recognition.

Three times in my life, I have had the same experience: While in New York in 1914, I gave lectures on psychoanalysis at the Liberal Club. I expected a small audience; however to my great astonishment some hundred persons were present. There was no room in the auditorium; I saw them standing before the windows and doors on Washington Square. I could not see the end of the crowd, and felt that Freud was transmitted by me to an unlimited number of people—to mankind itself. The same thing happened when Freud's medallion was unveiled at the house of his birth. On the four or five streets which joined before the house the crowd was endless. Again it happened when I spoke concerning Freud to Viennese students on his seventy-fifth birthday.

Since then, more and more, Freud's scientific work has become the common knowledge of the whole of literate mankind. The consequence is that more and more people are not satisfied with the surface appearance of pathological, of abnormal, and even of normal mental life, individually and socially. They know that there are concealed meanings, unconscious tendencies and complicated genetic developments—things deeper and more powerful than the manifest.

The common quality of all of the works of Freud lies in this: The symptom is the disease and is only the surface—the conflict and repressed drives are behind. These must be found and deciphered.

Errors, forgetting, slips of the tongue, of the pen, etc., are the manifest surfaces; the unconscious etiology is the interesting objective.

Psychosis and neurosis; character and resistances; social and political relations are the surface; in them, unconscious forces have to be revealed and checked.

However, such is the work of every originator in science—he is not satisfied with appearances and "standardized," accepted explanations. Freud has extended the natural science method over the whole of civilization. His influence has become enormous. No-

body today is satisfied by conscious knowledge of conscious motives. Whosoever seeks, or merely questions, repressed, hidden tendencies, motives and causes is co-worker with, and follower of Freud.

Freud was the strongest character I ever met. One must think of Galileo, Cromwell, Zola, Jefferson, Lincoln, to find his equal. He was convinced that any knowledge of the truth enables us to fulfill better any task of civilization—be it medical, psychiatric, educational, individual or sociological. However painful it is first to accept the truth, illusions and rationalizations must be recognized and given up. Then only can we become able to use the truth and to cope with realities. The discovery of the unconscious and of unconscious mechanisms is a painful step, but one aimed to *protect* civilization, not to destroy it. When Freud found that neurosis is the disease of our civilization, he never wanted to sacrifice civilization in order to avoid the neurosis, but he sought to find new methods to free civilization from the neurosis which endangers its existence.

For this reason, Freud is still with us, not only as an honored guest, but as leader and teacher. He recommends that we study his truth and understand it, not only to practice psychoanalytical therapy, but to teach and spread the conviction that the dreadful concomitants of civilization, neurosis and psychosis, criminality and psychopathy can be overcome, can be prevented. Psychoanalysis found that the adult suffers from the residue of unfavorable childhood circumstances. Psychoanalysis of the adult neurotic, or psychotic, or criminal, takes much time, and is hard work; belated because the injury took place long ago, and the consequences are strongly established.

But today the prevention of neurosis, psychosis, psychopathy and criminality, and of lesser degrees of maladjustment, through the mental and social hygiene of the infant, the child and the adolescent, are made possible through, and still need, the method initiated by Freud. The truth is a relief for the scientist whose doubt and anguish drive him forth to seek the answer. For everyone who wants to better conditions it is necessary to know the truth. On the other hand, it is pleasanter to ignore the truth, if one does *not* want to better conditions. Therefore Freud's revealing science of

the human mind and of the causation of mental disease is a challenge to us all. Not only are those of the relatively small group of psychoanalysts and psychiatrists his followers—all are. Civilized mankind remains his patient, until we have all learned to use his truth to establish mental health in civilized man.

Therefore when Freud's statue is erected here, may it be a symbol that he and his spirit are welcome and accepted in this country, not merely in this institute.

In this institute itself Freud's presence reminds us of the aims and motives and purpose of the psychoanalytic association. He foresaw that many shades and deviations and derivations necessarily would develop. In the international society, those may work together who want to continue and to complete the *whole* psychoanalytic concept. Only in this respect, are we "orthodox"; but we are open to every change which is progress—without abandoning the established truth and the principles confirmed by our scientific method.

That Freud's statue is here, proves that history fulfilled what in his lifetime was not accomplished. He was exiled from his home-land, and with him his European followers. They owe to the prestige of his name and his psychoanalysis the fact that they were received in the Anglo-Saxon countries and especially in the United States by their American colleagues. In our new country, our work continues. Therefore Freud and psychoanalysis are greatly indebted to American hospitality.

Freud came once as a "visitor" to New York. It is well known that, however thankful he was for acknowledgment, invitation and for much kindness he received here, he had the impression that there was not enough libido actually to be found and felt by him. When I myself enjoyed much hospitality in New York in 1914, I did not have this feeling. But I also formulated my parallel impression in the statement that the United States had developed the reality-principle to the highest degree, frequently *at the expense* of the pain-pleasure-principle. The Italian steward on the boat on which I returned to Europe said the same: "*America é soltanto per lavore niente per gioia.*" (American is only for work; nothing for joy.)

I think that all this has changed to a remarkable extent. Today, libido is not deficient in the United States. We have seen a remarkable example during the Second World War. While one understands that military organization is built on the reality-principle, psychiatric treatment was based on the use of libido, of transference, of understanding. In this war every soldier who became mentally ill was certain to meet kind understanding and to meet psychoanalytically-minded physicians and nurses. The organization of military psychiatry by Gen. William Menninger, M. C., was a major step forward, thanks to the acceptance of psychoanalysis by American psychiatry, and thanks to the acceptance of American psychiatry by the United States War Department.

The same is becoming more and more true in dealing with illness and social work, in general. Therefore the increase of active libido itself in this country is due, in some measure, to the influence of Freud.

I hope that his statue, too, will become a "resident" amongst us. His, Freud's, spirit is thankful to the United States which accepted his work, but it is also receiving the gratitude of the American people for the contributions of psychoanalysis to American science and culture.

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PRESENT-DAY STATUS OF MEDICAL PSYCHOLOGICAL ASPECTS OF ALCOHOLISM*

BY ROBERT V. SELIGER, M. D.

Although most workers in the field of alcoholism feel definitely that alcohol by itself does not produce alcoholism, nevertheless, it should certainly be kept in mind that alcohol is not an inert substance—like water. Pharmacologically, alcohol (at various stages of its effect on the human—and animal—organism) can act as a sedative, hypnotic, analgesic, narcotic, temporary anesthetic, and, in some cases, as a permanent anesthetic, producing death. The uses of alcohol as a relaxer and pain-killer are quite familiar.

Traditions and ceremonies of various types attend the use of alcoholic beverages.

Again, in regard to crime, one must keep in mind the following:

(1) Crime is often planned in a place where alcohol is sold.

(2) The tavern is the place where the criminal seeks his accomplices.

(3) The criminal is seldom courageous and uses alcohol to depress his inhibitions and allay his fears.

(4) The spoils of crime are often divided in the tavern.

(5) Alcohol removes the element of self-criticism from the criminal in relation to himself and his acts.

It should also be kept in mind, as the following material is presented, that the author is here attempting to give an inclusive survey of present-day scientific and factual concepts about this serious, and increasing, health problem. Such a survey requires the use of generalizations which concede the existence of qualifying generalizations.

In a practical, scientific-approach, survey, one is neither "damp, dry, nor wet" but one must consider the goal of sound health—physical and psychological—to be a basic imperative for us all in these days of turmoil and responsibility.

The fact that alcoholism is now the subject for medical-meeting discussion, civic forums, and industrial conferences, in contrast to

*Read at the Bimonthly Conference of the New York State Department of Mental Hygiene, Albany, March 24, 1948.

10 years or so ago when this problem was not even touched upon in many medical schools, much less recognized by most leaders, or was not under research, is a fact that is heartening and disheartening.

We should all be pleased if this behavior-illness problem were not so prevalent in our contemporary society. Its ravages are more varied, and worse than those of any other specific, known medical or psychiatric sickness. The toll it takes each year in lives, due to alcoholically-induced accidents; in happiness, due to marital and family-life upheavals, produced or increased by alcohol consumption; and in actual cash, from the home budget to state and federal funds is a toll greater than we can calculate, for the intangible, serious aspects of alcoholism—the symptom of illness —are at least as many as the tangible ones.

On the asset side of the definitely increased awareness of, and organized interest in, alcoholism, are the facts that today nearly all recognize that there is a difference between "social drinking" (even when hangovers are involved) and alcoholism; that the alcoholic is a sick person, not just a "bad actor," and that alcoholics as a class are no longer classifiable as "bums" and "drunks." Many of our most intelligent, versatile and useful citizens have alcohol problems. They are, medically speaking, alcoholics, require treatment for the underlying causations, and must learn how to live without ever again using this socially-acceptable, ever-present beverage, and also learn how to live in more satisfactory harmony with themselves and others. The nervous, irritable qualities of temperament that, aside from any psychiatric illness, so often underlie the drinking pattern, must be changed into calmer and more tolerantly-mature acceptance of distasteful facts. Treatment, by whatever method, consists essentially in this achievement: of helping an individual change (or strengthen) his personal reactions to the world he lives in and to other people, and of helping him never again to touch alcohol in any form.

Now, when we use the terms "social drinking" and "alcoholism," what is meant? Medically, an individual is considered to be an alcoholic if his use of alcohol interferes with one or more of his important life activities, as for example, his job-standing and ability, his reputation, his home-life. This interference is shown in

behavior, in his inability to stop drinking at will, in the fact that alcohol "handles" him; promises, resolutions, even threats are powerless against this domination. In contrast, the social drinker can stop drinking at will. He limits himself to several drinks, except at parties and even then usually stops short of actually getting drunk to the extent of not knowing what he is doing. The social drinker may, frequently, be injudicious in speech or action, but does not lose self-critical judgment sufficiently as to be involved in real "jams," fights with strangers, police, and so on.

However, *heavy* social drinkers—and their numbers appear to be increasing—*do* get themselves and others into difficulties; and this group constitutes a danger as an accident risk; also, from their ranks, the chronic alcoholic usually develops. Heavy social drinking, as such, from the medical point of view is, today, more and more a problem and should be dealt with through education and other measures. It does not, however, constitute alcoholism; although the writer, for one, certainly feels it can factually be called *incipient* alcoholism; that it should never be dismissed lightly; and that all precautions possible should be instituted to halt and eradicate it whenever it is known or suspected. Many business leaders, professional men, and "high-powered" executives would be found to be in this medical bracket. With the present world and national stresses subjecting us all to unusual nervous and emotional strain, such individuals are playing with dynamite as they drink their concoctions.

Further, I personally am convinced that heavy social drinkers actually cause more trouble, as a group—and this group numbers into the millions—than do the estimated three-fourths of a million alcoholics. The reasons for this personal conviction are based on some 20-odd years' experience in psychiatry and in observing the social climate of "our times." One need not go far for evidence. At any hotel bar or grill you may see at any dining hour a number of well-dressed, presumably influential men who, as the rounds pile up, become louder, more argumentative and more expansive in movement. When calm judgment in business or profession is required, alcoholic states of mind are comparable to a cut-off in electricity at the peak hour of production.

I am certainly opposed to prohibitionary measures, for they are opposed to the working of human nature and never produce any but poor to bad results. The solution for this heavy social drinking—in which, also, many, many women are participating and which, I believe, relatively few people recognize as a dangerous hazard—might be found in the building of social attitudes against behavior that is inappropriate, stupid, and harmful to others. The drunken driver and the drinking driver are potential killers.

Heavy social drinking, especially in the daytime, produces inefficiency. The executive whose bourbonized judgment dictates a business corporation letter and thereby loses several millions of the stockholders' investments, hurts and harms in a bloodless way. The clerk who, following the patterns set by his so-called superiors, also drinks at the noon-hour and makes typographical or other errors the rest of the day may, as a consequence, be fired. Or, he may mix things up so much that weeks are needed to untangle the matter, causing more work for others, and costing his company many dollars.

Such episodes of "absenteeism-on-the-spot," from the top down, are probably as many as, perhaps more than, those of orthodox absenteeism due to alcoholism.

If, through various opinion-molding media, we could change the prevailing social attitude about heavy social drinking and especially about daytime drinking so that instead of it being considered obligatory, or "smart," even the waiter would look astonished and disapproving, we should all be saved much trouble, and so far as automobile accidents alone, are concerned, much tragedy. And I do not think the liquor industry would suffer great financial losses. This industry, too, has the same problems of inefficiency, alcoholic errors of precision and absenteeism due to alcohol.

So much for social and heavy social drinking.

We have already defined medically an alcoholic as one whose drinking "handles" him and seriously interferes with his important life activities. But how did he reach such a stage—and what makes an alcoholic? We all know drinking people, even heavy social drinkers, whom we cannot call alcoholics. On the other hand, frequently we treat a patient for an alcohol problem whom the world would never consider an alcoholic, expecting from that term,

fireworks and obvious dissipation, such as Ray Milland portrayed in *The Lost Weekend.* Many a mild-mannered, immaculately groomed man, and woman, highly respected, comes under psychiatric care for alcoholism, who outwardly looks no different from any other—I use quotation marks—"normal" person. These individuals are certainly the hardest to treat and may be called the worst type of alcoholics, because theirs is an insidious, unseen, quiet, almost cancer-like form of drinking. Public opinion is not against them. Their own insight is very poor. They don't do anything "bad." Unless propped, propelled, and pushed by some unswerving relative, this type of drinker continues at large until—maybe—years pass before, like the one-hoss shay, he falls apart and his actual condition of alcoholism can be recognized. It is then, often, too late to do much, for irreversible organic brain changes have taken place.

In general, one may sum up the making of an alcoholic by the following:

He is a product of his ancestry, the way his grandparents and parents lived, the extent of their drinking, their racial background; of his personal early experiences in life, the inevitable clashes with other personalities, the likes and dislikes, the disciplines, the heartaches of childhood and how he assimilated or did not assimilate them; of, also, later experiences in life, from job changes to marriage or love experiences; of religion or lack of religion and basic belief, vague or less vague philosophy; of the social drinking habits of his friends; and of the social pressure to drink occasioned by those habits. This "pressure" is far more prevalent in some lines of work than in others. The average technician, for example, does not have to contend with the demands to "take" a drink that a salesman, especially of industrial commodities, does.

The alcoholic is also a product of his own inner drives or ambitions; and his self-esteem, or sense of prestige, may be so immature that he drinks to assert himself. And always there are biochemical constituents and changes in functioning, so that the psychobiological make-up and *its* changing functioning, its undercurrents, intertwine with the individual, with his present life-situation and problems (real, or felt to be real), and he consciously or unconsciously takes to the easily acquired habit of taking a drink for

a "pick-up." Frequently poor eating and sleeping habits over a period affect biochemical functioning so that alcohol is more quickly toxic.

Alcoholism as a psychiatric illness-symptom presents itself like the top of an iceberg. The submerged unseen part is what we must get a clear understanding of. It's not enough to say: "Don't take any more." Or: "I won't drink any more." The alcoholic, produced by all these factors just enumerated, in varying quantitative and qualitative amounts, is a very sick person whose drinking results from all the inner turmoil and/or rebellion which he attempts to allay and narcotize by alcohol, for him, a drug. Once the alcohol is taken away, the hidden part of the iceberg must be explored and fluoroscoped and dissected and enucleated and treated, if you will pardon this mixture of clinical terms. In fact, the alcoholic himself is a mixture of clinical terms. In part he is manic-depressive; in part, schizoid; in part, paranoid; in part, given to emotional outbursts resembling an epileptic equivalent. He is definitely neurotic; and, to the extent that so far as the seriousness of his drinking is concerned, his judgment is nil and insight poor, he is "psychotic." Small wonder that he has always been a thorn in the side of the medical profession. Even today, with all our vaunted knowledge about him, and our techniques of treatment, with all our clinics, "work-ups," lay groups and hospital arrangements, certain alcoholics can still be a source of trouble and confusion, equalled only by the out-and-out psychopath.

Because alcoholism is symptomatic of so many varied personality and behavior disorders, psychiatrists are becoming more and more interested in this serious problem.

The medical definition of an alcoholic—as distinguished from the social drinker—is one whose drinking interferes harmfully and definitely with one or more of his important life-activities. He may lose time from work because of drinking; or the quality of his work may suffer; or his home-life harmony may be disrupted; or he may so speak and generally conduct himself that his reputation and relationships with others suffer. In spite of evidence, clear to other people, that he is having difficulty with alcohol, he himself usually does not recognize the seriousness of the situation, partly because of the prevailing social attitude that having a drink or two

is a usual pleasant custom, an attitude that he has absorbed and that constitutes a form of "social pressure" until he can reach the place—if his brain is intact and his thinking "straight"—of admitting that just as the diabetic cannot handle sugar, so he cannot handle alcohol without adverse results.

Now, there are many types of alcoholics, and the need for careful discrimination is important both for actual treatment and placement and for a scientific application of the medical statement that alcoholics are sick people. In previous times, those with an alcohol addiction were usually considered as a group to be "hopeless drunks and bums." This attitude still exists in many sections and circles. However, we know it is not accurate, that not all with alcohol problems are "hopeless" and that many persons with these problems have high intelligence, fine, delicate make-ups and are among our community and social leaders. In the same way, in stating that "alcoholics are sick people" we must break down the generalization. To be of aid to the individual and family, one must first understand that alcoholism is symptomatic of psychopathology—disorder or illness in the personality-functioning, that the pathology may be primary, or secondary, that physical complications may be in the picture (organic brain damage or deterioration, etc.) and that in order to attempt to treat the patient we must know about his personality make-up, presence of any major psychiatric illness, of any minor psychiatric illness, and about his actual life-setting and circumstances.

Pharmacologically, alcohol depresses the "higher" brain centers, impairing or removing temporarily the brake-power of judgment, discretion, and control. Thus, primitive impulses and emotions are set free. Actually, alcohol does not make one "tight"; it makes one "loose."

There are individual differences in so-called "tolerance"—ability to drink without subjective or objective behavior, motor, or other changes; differences also for the same individual, depending on the amount of food in the stomach, emotional situations, fatigue elements, sugar metabolism, and so on; and there are different individual reactions to various alcoholic beverages.

In general, when alcohol is ingested it produces the following physiological changes in functioning:

Poorer co-ordination of thought and body action.

Diminished acuteness of sensory perception; delayed or weaker motor performance.

More frequent errors in precision work.

Diminished physical efficiency.

Pathology of Alcoholism

Formerly, alcohol was thought to cause definite heart trouble, kidney damage, and various other organ pathology. There has been little scientific evidence to substantiate these views. Aside from temporary symptoms resulting from an acute drinking bout, such as a thick-coated tongue, bloodshot eyes, and a gastritis of varying degrees, most of the pathology, as such, is found in disorders in the neuropsychiatric field. Occasionally, cirrhosis of the liver is found, which is associated with depletion in vitamin content, but it is also reported found in as many non-drinkers. Neuropsychiatric disorders include: encephalopathies of various types, neuropathies, and behavior disturbances (psychopathology), evidenced by personality, emotional, or mental deviations from the individual's usual behavior or that commonly accepted as usual by society.

Psychopathology

The following are types of reactions in which alcohol plays a very important part in producing the clinical picture. (In most cases these are associated with vitamin deficiencies because of inadequate food intake while drinking.)

(1) Acute intoxication with excitement.
(2) Acute intoxication with stupor.
(3) Acute intoxication with convulsions.
(4) Delirium tremens.
(5) Acute and chronic hallucinosis.
(6) Mental deterioration and dilapidation.
(7) Korsakoff's psychosis.
(8) Personality and ethical deteriorations.
(9) Chronic depressive reactions.
(10) Paranoid developments.

Psychodynamics

Since alcoholism is a symptom of a personality illness, an emotion illness, or a more serious psychiatric illness or disorder, one attempts through careful examination to uncover the causes and/or psychodynamics producing this symptom, which may be evidence of primary psychopathology or of secondary psychopathology. For purposes of convenience, we can summarize these as follows:

(1) As an escape from painful life-situations.

(2) As an attempt to escape from one's self—evidence of maladjusted personalities.

(3) As a combination of these two.

(4) Evidence of neurosis.

(5) Evidence of psychosis.

(6) Evidence of feeblemindedness.

(7) Evidence of psychopathic personality.

(8) Evidence of some epileptic conditions.

(9) As a result of heavy social drinking, habit, time, body changes and strains of life.

(10) As an escape from incurable physical illness.

The individual "psychodynamics" of why people drink is a question now productive of so many answers that the whole issue of treatment, including prevention, has become rather obscured. Individual motivations for excessive drinking may be summarized as follows:

(1) A self-pampering tendency, which reveals itself in a refusal to tolerate, even briefly, any unpleasant state of mind—boredom, sorrow, anger, disappointment, worry, depression, dissatisfaction, and feelings of inferiority and inadequacy. A childish demand for: "I want what I want when I want it because I want it," perhaps expresses the attitude of many alcoholics toward life.

(2) An instinctive urge for self-expression without the determination or staying-powers to organize this urge into creative productive action.

(3) A more than usual craving for emotional experiences which call for the removal of intellectual restraint.

(4) Powerful hidden ambitions without the necessary resolve to take practical steps to attain them, with resultant discontent, irritability, depression, disgruntledness, and general restlessness.

(5) A tendency to flinch from the worries and responsibilities of life and to seek escape from reality by the easiest available means.

(6) An unreasoning demand for constant happiness or excitement.

To repeat, alcoholism is felt to be evidence of an escape from reality; or of a maladjusted personality; or of latent or overt homosexuality; or of intense unconscious self-destructive tendencies. We feel that any one of these interpretive conclusions verifies the presence of anxiety, hostility and/or tension; and psychiatric probing by various methods may bring out as their cause:

(1) Some early traumatic event.

(2) Disturbing experiences at certain periods of life which the individual's personality was unable properly or satisfactorily to assimilate.

(3) Identification and imitation factors, rather than any inherited disposition toward alcoholism.

(4) Conflicts causing "pent-up" charges which require narcotizing either the anxiety itself or the anxiety-controls.

So far as treatment is concerned: First, it is quite obvious—even to the non-medically, non-psychiatrically trained "average person"—that many alcoholics have been able to stop drinking via many so-called approaches. Some stop by themselves, unaccountably, or "for some reason or another"; others stop because of a religious experience or conversion; others by and with the aid of social workers. Some stop drinking with help from lay therapists; some, with help from lay groups; and others, from lay-and-religious groups, if one may use that term, such as, for example, The Salvation Army.

Even the old "Keeley Cure" helped many alcoholics and some are now advocating a conditioning treatment without psychotherapy; while many, with deeper interest, use the conditioning, or aversion, treatment in order to get a beach-head on the patient and then follow up with psychotherapy.

Psychoanalysis alone, hypnosis alone and hypnoanalysis alone have all been rather unsuccessful.

From the medical psychological and psychiatric point of view of treatment, each individual presents an individual problem and must be handled as such. However, in general, the methodology can be described as follows:

First of all, one wishes to determine what type of psychiatric problem one has to deal with; how much deterioration is present; how serious is the extent of the drinking; whether the individual really wants help.

Remembering that a man or woman with an alcohol problem may come or be brought in any stage from that of acute delirium tremens to that of the remorseful hangover period, and that the sources of referral may range from the jail to the president of the company (or the president's wife), one should deal practically with the problem at the time. The method of selection follows the general lines enumerated below:

(1) The individual who desires to abstain but who is unable to do so by himself. This patient has good intelligence, some maturity in his make-up; and his life-habits and contacts indicate stability. This type is to be handled by extra-mural or office therapy of regular, frequent visits which are the patient's responsibility to keep—with sedation as indicated.

(2) The individual who desires to abstain but who is unable to do so by himself. This patient has good intelligence, some maturity in his make-up, but his life-habits and contacts are poor. He should, therefore, be placed in a non-institutionalized farm arrangement, where psychotherapy, including help and guidance away from his contacts, is started.

(3) The individual with good intelligence and rather immature make-up who should abstain but does not desire to do so. Most in this group have poor habits and contacts, although some do not. This type should be placed on an alcohol farm, sanatorium, or hospital under the "Inebriate Act," for a definite period.

(4) Korsakoff's psychosis and alcoholic deteriorated patients should be treated in mental hospitals.

(5) Individuals with delirium tremens and acute hallucinosis should be handled and detoxified in the office equipped and pre-

pared to do so, or placed in acute psychopathic hospitals and then studied in the way described for future handling.

(6) Feeble-minded individuals with a history of repeated arrests, commitment to the workhouse or house of correction should, after careful examination, be handled by the penal system.

(7) Chronic alcoholics should not, of course, be treated in general hospitals, which are not equipped to handle this problem, where treatment is usually mere de-saturation and discharge at a time when the individual is psychologically demobilized and ready for another bout. This pattern of acute intoxication, brief de-saturation period and resumption of drinking, is easily established and leads with more or less rapidity to involvement of the central nervous system. It is felt that this type of superficial therapy has contributed to a great deal of the fatalistic attitude of some lay and medical groups about treatment of alcoholics in general, and to the feeling that "all drunks are hopeless."

This method of selection is based on data obtained from the patient and/or members of his family, social service or other agencies. As in any psychiatric examination, one needs to know all the important life-details and facts. With the non-intoxicated, non-deteriorated patient, who may be interviewed in the office, or at the hospital after he has cleared up from the effects of drinking, a complete history is taken from birth to the present. This should include the patient's place in the family group; developmental data; the presence or absence of disturbing behavior or situations in childhood, adjustment to school, vocational record, marital status, sexual activities and attitudes, religious habits and feelings, financial status, family situations, general health throughout life (including details of major illnesses or operations or accidents), and a close survey of the present life-situations and persons involved.

A psychiatric examination also includes the formal mental status of general behavior and habits, activities, mood, special preoccupations, sensorium and intellectual resources, and insight. To determine the presence of any organic pathology, a physical and especially a neurological examination should be made, with specific laboratory tests as indicated. A member of the family, or close friend, should be interviewed in order to obtain objective data

about the drinking problem, drinking behavior, and general personality of the individual, with emphasis on his assets and good qualities as much as on the difficulties his drinking has caused. (The examination should also include personality depth-studies through use of the Rorschach analysis or the Murray Thematic Apperception Test. The sensorium and intellectual resources are further tested by the Kohs Blocks test, the Wechsler-Bellevue Adult Intelligence Scale; electroencephalogram and other tests are done as indicated.)

Based on all these findings, one should prepare a more or less detailed summary of the patient's assets and liabilities to aid in understanding and medically treating him as an individual. A similar examination-interview with the mate is extremely important to help find out how great a part, if any, the friction of personalities has played in contributing to the production of strains or out-and-out irritants that the individual sought escape from via drinking.

Treatment

No one who has had an alcohol problem can ever again drink "socially." Science does not yet know exactly why this is so—what change has taken place in cell tissue—but pragmatic experience has proved beyond doubt that once a person's drinking has crossed the line to pathological drinking, he can never "handle alcohol" again. He can reintegrate his personality and often achieve more than even in the early, "social drinking" days; but he must be a total, permanent, forever-after abstainer.

These facts must be bluntly stated at the outset, and accepted by the patient if desired results are to be expected. Frequently it is possible to modify poor vocational adjustment, or irritating marital situations involving sexual incompatibilities, parental conflict over the management of children, and so forth. The patient himself may not be conscious of the strains of all these things upon him. When it is not possible to modify the situation, it is often possible to change the patient's attitude toward the difficulties he has to meet. Many a person becomes morbidly self-accusatory and fatalistic because of what he considers his failure to modify the unmodifiable. Such an individual may be greatly helped by mutual discussion, constructive criticism and wise guidance.

The goal of treatment therefore is to teach the individual who can be helped, to learn how to live without ever again using alcohol in any form.

This involves usually a rather lengthy rehabilitation period of habit-training, re-directions in life, and helping the patient to learn intellectual control over mood (emotional) domination. Individual therapeutic interviews utilizing the principles of ventilation and desensitization on a distributive analytic basis help give the individual a chance to "let off steam" and react less strenuously to previous upsetting situations or conflicts, and also give him insight into some of his modifiable drives and attitudes that cause him difficulty. He is indirectly taught to accept tolerantly and maturely other people's personalities without feeling unnecessarily "blocked" or frustrated, and a careful appraisal of his personality liabilities and assets helps him to reorganize his views and values and goals and capacities along more constructive, satisfyingly-productive lines.

We must always remember that while many individuals drink to relieve various feelings of discomfort or psychic pain, others drink as part of a more serious psychiatric picture involving mood-swings or schizophrenic features, and so on. Need for thorough examination, and understanding of the underlying personality illness or disorder cannot be over-emphasized.

For all these reasons, interviews with the husband or wife or family members assume major therapeutic importance. Many a poor result of treatment is attributable to lack of any insight whatever on the part of those closest to the patient; they too must learn to accept unmodifiable facts of life and to utilize principles of emotional hygiene in their interpersonal relationships.

Success in Treatment

Experience with alcoholic patients indicates that successful results are accomplished by the following factors:

(1) Careful selection of patients: that is, those who desire to learn how to stop drinking, who have average or better intelligence, some level of emotional maturity, undamaged brains, with place of treatment depending on their business, home, social contacts, and so on.

(2) Personality of the psychiatrist, who should be plastic, sympathetic, tolerant, but firm. (Ideally, it is important for the psychiatrist and staff-members to be total abstainers.)

(3) Distributive analysis and psychotherapy with personality discipline, re-education, desensitization and ventilation.

(4) Adjunctive vitamin and/or insulin therapy in controlled dosage, to aid in the biochemical functioning.

(5) Interpersonal relationship of patient and therapist.

(6) Suggestive influences, including community and civic activities.

(7) Interviews with the mate or family members.

(8) Full co-operation of the patient and his associates.

(9) Intensive follow-up for a period of many weeks, and continuous follow-up for life, by means of correspondence, phone calls, annual visits, and so on.

Prevention

On a broader basis, alcoholism now constitutes a major national health problem, all workers in public health and welfare agreeing that all too frequently alcoholism is one of the outstanding factors in the production of serious difficulties for individuals and the community. As one example, many a juvenile delinquent comes from a home broken up by the effects of alcoholism.

The need for preventive education and understanding is great. Recently much more attention has been focused on the problem of the alcoholic individual and in many states and cities, committees have formed to handle or attempt to handle this problem. Because the serious implications of alcoholism lie in the field of behavior, medical psychiatric supervision is needed properly to guide individuals and groups desirous of "doing something about" alcoholism.

It is important to keep away as much as possible from emotional, political, or other attitudes that might obscure the clear fact that treatment of the alcoholic himself is primarily a medical rather than a moral problem. Wise preventive education should consist of recognizing that, in general, excessive "dependent" drinking is a frequent result of poor, unsatisfactory emotional and other life-habits apparently associated with some of the contemporary social

pressures of speed, noise, change and general insecurity in nearly all spheres of life. The use of alcoholic beverages is traditional in most parts of the world and previous attempts at regulation have failed to get at the root of the problem because the problem is inherent with the individual himself, his personality and the specific life-setting with all its frustrations, frictions, and the like, in which he finds himself.

We feel, therefore, that information centers where problems of alcoholism could be referred, associated with treatment facilities to handle acute problems, (a psychiatric hospital or unit) adequately staffed with trained personnel (psychologists, nurses, social service workers) under the supervision of a psychiatrist, offer the most practical working program for the community and the individual. Affiliated services would include farms where selected patients could receive psychotherapy and common-sense re-education in life; and protective institutional arrangements for the more serious psychiatric types, including the feeble-minded and psychopaths—the last constituting, of course, the most difficult rehabilitation problem.

In conclusion, alcoholism is a serious national health problem and it is also a social problem requiring new and different social attitudes about excessive uncontrolled drinking. The alcoholic is a sick person who needs competent proper medical and psychiatric care, treatment, and follow-up supervision. The only possible goal for the alcoholic lies in his never again taking a drink. The only possible goal of treatment, along whatever lines, therefore, is the well-known fact of total permanent abstinence for the ex-alcoholic. The ex-alcoholic should not be made to feel, either in the home or community, that his illness was a crime. He should receive every possible proof of moral support in maintaining his health and the same sort of consideration—no more and no less—that an ex-tuberculosis patient receives.

To aid in the prevention of alcoholism, greater stress on sound physical and mental health habits and on the emotionally important elements of family and religious life, with lessened pressures of speed and dollar-sign success would, we feel, help decrease the production of many emotionally immature, early neurotic, early psychotic, and incipient alcoholic personalities. One need not enu-

merate today, the terrific sociological pressures upon every one of us, and the consequent need to maintain health in all ways.

From the practical standpoint, prevention and treatment both, would be best organized and instituted to serve the community through:

1. Information centers (similar to those maintained by our tuberculosis, cancer, rheumatic heart associations) where material could be obtained by the public and through which contacts with medical and psychiatric set-ups could be made.

(2) Thorough, factual courses on alcoholism, its treatment and prevention, given in all our medical, nursing, and social service schools.

(3) A hospital or section of it in every state where patients with alcohol problems could be properly treated and given the medical-psychological service they require.

(4) State hospital set-ups for the treatment of certain alcohol patients.

(5) State farms where physical rehabilitation and social psychiatric help under the supervision of a psychiatrist would be available.

(6) Extramural clinic centers, located near the "alcohol hospital" or information center, to serve as diagnostic units, treatment units, social service units, and training units for workers in this field of behavior illness.

(7) A concerted program of education against *heavy* social drinking, beamed at the reading and listening public—including the 'teen and twenty-agers—and supported as a public health service.

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THE PSYCHOLOGY OF THE JAPANESE

BY HIRSCH LAZAAR SILVERMAN*

The United States was spectacularly locked, until rather recently, in the closest of all relationships, *war,* with Japan. We need even now to reckon with the country and people of Japan for the sake of our individual and national well-being. Our task has been increasingly difficult, for we have had to *understand* the bridge, the abyss, that lies between the two peoples' ways of life, our laws, our aims, methods, motivations. More and more, we are coming to understand the paradoxes of behavior that have twisted the Japanese mind for centuries. Such understanding helps us to explain how the Japanese could attack us in the first place, and to explain their apparent dilatory actions in arranging final peace terms after they had agreed to surrender.

Through the Japanese institutions and concepts, we have a means of understanding the Japanese people psychologically. To aid in comprehending better the orientalism, or *orientalness,* of the people of Japan, the following account of their structure is presented, with emphasis laid on the historical and social aspects of their culture which are at once unfamiliar to occidentals and of special importance in determining Japanese attitudes and behavior.

Japan is essentially an old, stable, peasant society—suddenly transformed into an industrial nation. Legally, the traditional rights and obligations of both master and apprentice are maintained: the master to house, educate, and train; the apprentice to work, obey, and learn. It is noteworthy that this concept is followed in the major aspects of Japanese categories of life.

Americans are always wondering about the Japanese—about their attitudes, thoughts, ideas, actions. Even after a comprehensive analysis of the Japanese philosophy of life, we shall have reservations in our minds; we shall discount, and be automatically skeptical about, things Japanese. Basically, this is a rather natural tendency; for Americans like to think of themselves as being "scientific" and "exact," and anything that borders on the philo-

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sophical is left open "for further examination." Now we realize, however, that the mental and emotional behavior of foreigners is best understood through personal contact and study.

Now the instinctive curiosity of Americans is helping them gain insight into the manner of men, women and children that make up the Japanese people. Just as among other peoples of the world, there are various *types* of minds among the Japanese; and, throughout Japan, is to be found a culture *differing* from our own. The west and the east meet—as they have never met before—in the military occupation of Japan. For the first time truly, the east and the west will become acquainted. Today the peoples of the two worlds live together and they are learning each other's customs. It is almost ironical, too, that these days—as strangers in a foreign land—Americans live rather peacefully among a people with whom not long ago they were fighting. . . .

The psychologist sees the Japanese bowing and smiling, and this seems odd to him. The American thinks of bowing in a different concept; and he cannot understand the act of kowtowing. The American is struck by the contrast in ways and manners. Under democracy, our lives are so different from those of the Japanese. But does this mean that there cannot be understanding?

Does bowing, for example, represent an inbred feeling of inequality and humility, or does it actually signify politeness? And more: Are the Japanese honest? Are they sincere? Is their smile a sham? Do they actually want to be free and realize at long last, a democratic way of life? How could they fight so fanatically for a governmental set-up they can now spurn so readily, so quickly? Are the Japanese people truly peaceful, polite and humane?

It is not yet time for the psychologist to give his verdict, for no real and strong verdict is possible now. An analysis of the make-up of the Japanese people is, however, in order; at least it will serve to make clearer the pattern of their behavior, their conduct, their psychology. The unfortunate misconception exists that the Japanese are a people who are not, and cannot be, understood. No human being, or group of human beings, has personality that is insoluble or incomprehensible, just as there is no other phenomenon that is without the possibility of interpretation or defini-

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tion. However, to be sure, there are paradoxes and contradictions in the Japanese character.

Some conspicuous psychological characteristics of the Japanese are described and analyzed in this article. However, it must here be pointed out, the distinctively Japanese psychological aspects often are intangible, since they are found in emotional habits rather than in outwardly visible behavior. Typically, the Japanese reconcile glaring inconsistencies by convenient rationalizations.

Despite the inflexibility, the duplicity and fatalism of the Japanese mind, the character of the Japanese is essentially simple. He is a predictable being, because of his utter practicality. The man in the street in Tokyo had known, since about 1930, that inevitably America and Japan would fight. The Japanese, who puts feeling before reason when under pressure, even looked upon such a war with an irresistible fascination—a war either for domination or for extermination, for national suicide, if necessary. It was a kind of picturesque challenge with its odds and its stakes—for the Japanese to fight a country like American.

It is needful for all Americans to have insight into the Japanese as a people, as a psychological entity, if we are to *know* those orientals comprehensively, impartially and clearly. In explaining their social structure and ideology, we are not excusing such aspects as are deplorable and abhorrent. No understanding of Japanese culture is possible unless the utter contrasts of the prevailing eastern and western moods and traditions are taken into consideration. What follows, are objective inductions from historical facts. Interpretations and criticisms, dependent upon opinions and outlook, are left to the individual reader.

Are the Japanese violently irrational? And how are we to explain their self-destructive behavior pattern? What of the strength of their Shinto-inspired patriotism? Does the peculiar form of their language affect their very nature? What of their philosophy of life, and how are we to understand their psychology?

We hear that the Japanese have pride in nation, and we wonder as to its ramifications. Analyzing this concept objectively, we find that the Japanese carry national pride to the extreme of chauvinism. To them, their Emperor is a god; their land is divine,

is insoluble or incomprehensible, just as there is no other phenomenon that is without the possibility of interpretation or defini-

born of the gods; and they themselves partake of divinity. The Japanese soldier is boastful, not for himself alone, but for his people and his country. His boast, "I am a Japanese," to his mind explains everything, justifies everything.

Then there is the dual personality of the Japanese to consider. Theirs is a strange personality-dilemma: They can be at different times both refined, kindly and of delicate taste, and yet of great brutality and inhumanity. Their dual personalities allow them to be the perfect hosts, and also sadists and murderers. This dichotomy in Japanese life lies in the fact that the Japanese have long been schooled both in their responsibilities toward their immediate families and relatives, as well as in their records of long-term, imposed restraints. The Japanese have been regimented, from the cradle to the grave, by their government, by strict traditions, by teachers, parents, police, and officers in the army. Their emotions are repressed, frustrated. Relations with each other are graded in obsequiousness according to their station in life. They are constantly concerned with the minutiae of existence. The Japanese are at times fierce and gentle; sentiment can cause them to weep like women. They are moody and melancholy, but put up a front —"a saving of face"— for outward appearances.

An understanding, then, of Japanese psychology will be of much help in handling future relations with them as a group. (When I speak of the Japanese "psychologically," I refer to their culture in the scientific sense, as denoting all behavior—customs, beliefs, traditions—the pattern of which is learned from observation, study and understanding.) For the lives and minds of the Japanese allow for few privacies; their crowded living conditions, *shis* and *muras*—a bedlam of thousands of people camping all over their living areas in small, inadequate hutments, with hundreds hustling and jostling through the streets every hour of the day—are carried over into their governmental structure! There is no abstruseness or vagueness about the Japanese mentality. It is only our ignorance of the Japanese that makes for our own misunderstanding. A psychological interpretation of the Japanese can serve to distinguish between history and mythology in Japanese culture and thought.

I

Japan presents the first historical instance of the adoption of occidental cultural forms and mechanical devices by a people whose mentality, goals, and ideals differ from those of occidental peoples. As a result, conflicts in ideals, customs, and desires characterize the Japanese people. Ethical conduct—the habit of taking into account the welfare of others in all one's dealings—is not understood, as such, by the Japanese. Their tribe-centered behavior, their ethnocentricism, makes them different, particularly from Americans. With the Japanese, abstract principles carry no weight beyond intellectual curiosity; custom and emotion are the bases of conduct.

Let us consider briefly Japanese philosophy. Japanese philosophy is based on complete disregard of contemporary viewpoints. The Japanese are fatalistic; their philosophy of *shikataganai* (things are as they are, and cannot be helped) is widespread. Other people deserve what they get out of life, the Japanese argue, so why worry about them? Their philosophy is built around intuitive meditation, an introvertive nature. They tend to disrespect anyone who shows a cheerful manner. To the Japanese, life is a solemn matter. Sentimentality and tenderness, born of pity for the inevitable sorrow of life, are accentuated traits in Japanese character. In their aesthetics there is the concept of *mono no aware* ("beauty-plus-pathos"). While enjoying small things in their families and in nature, they are constantly mindful of the sadness of life.

An interesting fact in their "way of life" is that the Japanese have a passion for unity. Every individual is exhorted to subordinate himself to the whole group. The family is a strong unifying force. The Japanese give themselves little opportunity for personal self-expression. There is constant emphasis in the home and school on solidarity. Individualism is looked upon as selfishness. It is felt that the misdeeds of any child in a family besmirch the family name. Accordingly, pressure is exerted to protect the family reputation. The word of the father is law. Beyond the family, lies the State. Education is bent to the inculcation of absolute faith in the myths of Japan. The Japanese have

developed a fanatical pride in race, and their patriotism has the added sanction of religion. The organization of the Japanese nation into neighborhood groups (*tonari gumi*) for mutual self-help, to carry out government orders most effectively, illustrates the extent to which the Japanese are willing to be regimented.

The Japanese as a people have a distinct fear of ridicule and are especially sensitive to criticism. Their feeling of shame is very keen. Children are encouraged to build up objective standards of conduct. The Japanese people are expected to camouflage the sins of Japanese society, the poverty, the prostitution, the slums, are expected to protect the name of Japan. Ridicule is an effective but dangerous form of punishment for the Japanese, for the concept of "saving face" is important to them. (When a Japanese himself wishes to show profound contempt for someone, he acts brusquely and rudely toward him.) Basically, the Japanese are sensitive, emotional, and quick to take offense, regardless of their outward characteristics.

Then, too, the ethics of this confusing—and confused—people need clarification. To the Japanese, the way a thing is done is just as important as what is done. They consider good form to be the better part of ethics. Skill in flattery, in returning graceful compliments, is an important Japanese social accomplishment. Politeness is usually more important than honesty to the Japanese; accordingly, conventional lies are common in their social and business life. (In this regard, it is interesting to note that the Japanese infringe with impunity on patents and copyrights.) The Japanese concept of *yumei mujitsu* (having the name but not the reality) indicates that in their thinking there is often a wide gap between their theories and the actual performance. In their propaganda techniques, they feel that a thing becomes true if it is repeated often enough, or stated emphatically enough.

In spite of the attempt of Japan to emphasize racial and cultural homogeneity among its own people, there are actually many class distinctions and social stratifications, some ethnic, some economic, and some based on inherited rank. The following social classes are distinguishable even today: (1) the imperial family; (2) the nobility; (3) the business magnates; (4) the middle classes; (5) the

technicians; (6) the farmers; (7) the urban proletariat; and (8) the *Eta,* a kind of commoners, an outcast group.

Religion was unquestionably a more important force in Japan as a dictatorship, than in either Germany or Italy; but conversely, it was not an obstacle to the leaders of Japanese totalitarianism. The Japanese militarists were not obliged, as were the Nazis, to invent new dogmas, symbols, and rituals. In Japan, ancestor worship has survived from early times to the present day. Then there is identification of the imperial cult with the national cult, and the superposition of the worship of the imperial ancestors over the worship of clan and family ancestors. This explains in part the loyalty of the people to the emperor and their patriotism toward Japan itself.

In Japan, too, religion and national life are united and interdependent. (Even the word for government, *matsuri-goto,* signifies literally "affairs of worship.") The Japanese term *saisei ichi* means the unity of religion and government. Ancestor worship is required of all Japanese and takes precedence over other forms of worship.

In brief, the dogmas of Shintoism are the belief in unbroken divine imperial sovereignty; the belief that Japan is the "Land of the gods," that the Japanese are a part of divine nature and of special concern to the gods; and the dogma of benevolent destiny which holds that Japan has the sacred mission to save the world. Understandable, then, is Japan's slogan, *Hakko Ichi-u* ("The Whole World Under One Roof"). Religion in Japan was prostituted to the war effort, by being used for propaganda purposes. Even *Bushido* is in its effect an aspect of religion, with its emphasis on abstract loyalty without thought of reward, a loyalty above all personal considerations; a loyalty to leaders of groups, and to groups themselves; and above all, loyalty to the emperor.

We consider, finally, the language of the Japanese people. We find that there is very little dialectical variation in their language. The original Japanese language, *Yamato,* was a primitive spoken language; and, unlike most of the other important languages of the world, Japanese belongs to no known "family" of languages. From the sixth to the nineteenth centuries a wholesale borrowing

from the Chinese vocabulary more than doubled the Japanese language. (The Japanese have also borrowed from western sources for the formation of some 5,000 new words.) Some of the Chinese characters were abbreviated to form the *Kana,* or the Japanese syllabary, of 51 characters.

The very nature of the language influences the character of the people: Japanese does not lend itself to exact and scientific expression. An idiom explaining almost any sort of behavior is *Kimochi no mondai desu* (which implies a generalization requiring interpretation, a question of feeling). Japanese is wordy and illogical at times, with purposely indefinite and implied meanings.

A few comments about the geographical factors of Japan are pertinent for a better understanding of the people. Japan proper is an archipelago of about 500 islands with a combined area of 146,690 square miles, which is slightly less than the area of California. Four large islands—Hokkaidõ, Honshu, Shikoku, and Kyushu—form the backbone of the archipelago and comprise most of its area. Japan is a land with lofty mountain ranges, high plateaus, abrupt interior basins, moderately rugged hill country, steplike coastal terraces, and flat coastal plains. Much of the shoreline is backed by steep cliffs. Along the rest, the coastal plain varies from a narrow strip to the large Kantõ Plain of 2,500 square miles upon which Tõkyõ, the capital, is situated.

There are several active volcanoes on the islands, and earthquakes are frequent. The climate varies from that found in New England to that found in the Southern States. The population is approximately 72,000,000, with the majority living on the Pacific side of Honshu, and on the parts of Honshu and Kyushu bordering the Inland Sea. Within these areas are located six metropolitan centers.

The Japanese racial characteristics have been generated, fostered and made more and more articulate by varied causes and circumstances. The historical peculiarity of the Japanese—in their history they skipped the pastoral interlude or stage sociologically—together with the influence of Buddhism, came to make this people wince at the idea and practice of eating the meat of slaughtered animals. Psychologically interesting, too, is the fact that Japanese children generally show less affection for dogs and cats

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than children in America. It may be said that their history in large measure shapes and governs the way of thought of the Japanese as a people.

The weather of Japan is, again, an important factor in the life of the people, for in the main they are agrarian. Although its chain of islands lies in the temperate zone, Japan stands at the crossroad of tidal and atmospheric currents. The weather, therefore, is extremely fickle. Thus, in the course of centuries, the weather—moderate but changeable—seems, anthropologically, to have left its indelible marks on the Japanese character.

II

In Japanese history, military virtues have prevailed as the primary virtues of society. The processes of militarism involved virtues of organization, of discipline, of the subjugation of the individual to collective advantages. Internal peace means external isolation to the Japanese; and their living amounts to a technique of control. Even military notions of organization are based on national objectives. Their *Bushido* concept had various assumptions and inferences, and the following are some of the tenets: the simplicity-of-life principle, principle of loyalty, practice of virtue, principle of sacredness of the word, principle of fulfillment of personal obligations, principle of self-control and self-discipline, principle of precision of plan and of action, principle of complete mental discipline, principle of rigid etiquette, principle of contempt and lack of mercy for enemies.

There is also in Japanese history the well-known mental habit called *enryo,* one of the most deeply ingrained racial qualities. It is actually an inhibition so characteristically Japanese that it cannot be adequately translated by any single English word. It vitally affects Allied-Japanese relations, and its importance in the conduct of foreign relations, that is, its effect on Japanese understanding of the psychology of alien peoples, with all attendant difficulties, is not to be minimized. *Enryo* even prevents the Japanese people from discussing their problems effectively among themselves and stands in the way of any real expression of public opinion.

Giri, inadequately translated "duty," carries stern implications for the Japanese. Another translation, "sincerity," is commonly used; but the word does not imply transparent harmony of motive and performance; it rather implies single-minded pursuit of a goal, at any cost. "Righteousness," to the Japanese mind, means obedience to authority. Rarely is the individual Japanese led to change his conduct by an intellectual argument, even though he may admit its cogency; he acts as he feels, not as he thinks.

The position of women in Japanese society has changed considerably since Japan's feudal times. Now they are receiving democratic voice in the government. Until recently, however, there were specific "womanly virtues" engendered in women-folk, e. g., constancy, willingness to endure hardship, to accept fate, to accept the dictates of authority. In fine, women were to be considered as lacking in actual freedom; their paramount virtue of passive submission was predicated on their acceptance of male domination.

There is no such thing as *the individual,* or *personality* as such, in Japanese culture. Yet, as a people the Japanese are most individualistic in temperament; and their ways of thought differ from occidental viewpoints. No one Japanese ever will assume individual responsibility in his own name, unless to shield the sovereignty of the emperor; for the Japanese are just not "constructed" that way. The Japanese idea is that no one individual can think for the entire empire; no individual is considered trustworthy enough for all the people. It follows, then, to their way of thinking: How can any one person be responsible for the government's acts? This concept is a process of some 1900 years of independence. The fact that until 1945 no foreign nation ever invaded or occupied Japan, is to the Japanese very significant, and gives them a basis for their so-called "divinity." This feeling may well be termed an "internal awareness" that their land is protected by the gods they worship. It is a kind of sense of determination.

Distinctly removed from their other traits, there is the Japanese technique of intuitional lying. Japan can boast of no martyrs to principles; neurotic concealment is substituted for devotion to abstract ideals. Many Japanese are contemptuous of good faith and direct speaking, as worthy only of simpletons. This is, in form of

behavior, a psychiatrically neurotic or psychotic symptom. The Japanese may disagree vehemently with an opinion or statement; but, to appear polite and not discourteous, they assent to it outwardly. They may believe at the same time that a contrary action to the one agreed upon will follow later; but, for the time, they are content to agree, knowing full well that before long they will act to the contrary.

This factor may be labeled *intuitional lying,* for it is a part of the Japanese character from that of diplomats to that of houseboys. Much that the western mind calls courtesy, is, to the Japanese, innate obedience and kow-towing. There is, too, an extréme class-consciousness among the Japanese people, and they are hypersensitive to comments and observations, even of their neighbors, let alone outsiders.

The Japanese have emotional tautness and strain in their personalities. Such tension—outward signs of inner conflicts in the individual—may be reflected in their leanings toward aggressiveness and cruelty; it leads to the anomaly of a sensitive intelligence combined with sadistic brutality, for insecure and fearful persons may be both sensitive and cruel.

The individual Japanese is emotionally repressed and at war with himself. The general life of the Japanese affords him little of the personal security that is founded in tender affection and encouragement. Emotion is preferred to intellect as a guide to conduct. Strangely enough, the Japanese study ideas and philosophies of many kinds, but then discard abstract thinking and factual reasoning in favor of primitive emotion when actual conduct is involved.

The Japanese people have an indirect approach to most problems. The oriental mind likes to "size up" those which come before it. The individual Japanese prefers to consider all angles of any proposition whatever. In retail business, in social exchanges, in conversation, in family dealings, he expects others to grant him time enough to think, to plan, to ponder—and to digress; but in time he does come around to some conclusion. For time, as such, measured by clock-hours and the calendar, is not important to the Japanese.

III

There is a strange dilemma, a paradox even, in the psychological problem of Japan. The Japanese as a people are law-abiding; yet, militarily they were violators of all ethics and of the rules of humanity. In their own country, the dictates of law are magnified and exaggerated in their minds. Whereas in democracy, laws are made; under Japanese dictatorship, laws were the will of the emperor and his delegates; and the people of the nation were not to question any laws or regulations, but were to accept and acquiesce. However, in a foreign area, the Japanese feel free to throw off the bonds of obedience to law; and the concept of self-rule is negated.

Under the Japanese constitution the freedom of religious belief and liberty of speech, and other such rights, was qualified by the clause "Except in cases provided by law" and, more, by Article 31 which reads ". . . other rights shall not affect the exercise of rights appertaining to the emperor in time of war or national emergency." It is apparent, then, that the Japanese constitution provided no safeguard against restrictions of civil rights as long as such restrictions were the product of law. Obviously, the absence of a tradition of individual freedom, of the writ of habeas corpus, and of other representative institutions had facilitated in practice the negation by law of many of the rights for which the constitution seems to provide.

Let us not be deceived by the Japanese emphasis on "law" in their regulations. Even executive ordinances have been a fruitful source of limitation of the civil liberties of Japanese subjects. The Japanese practice of couching legislation in the most general terms, leaving the details to be filled in by ordinance, has produced a large body of restrictive executive ordinances. The denial of civil rights in Japan is further typified by the *Peace Preservation Law,* first passed in 1925 and revised since in the direction of increasing strictness, which imposes severe penalties, including death, on those who support movements vaguely defined as intending to produce changes "in the national polity" be it by word, deed or monetary contribution.

There is a powerful consideration—psychologically—in the Japanese problem: Namely, the Japanese are almost the embodiment,

the accentuation, of the state of tranquility. They cannot fully conceive of turmoil or tumult in their personal lives. The establishment of immutable and inflexible law impresses them. A democratic interpretation of law is not allowable: The law is to be *the* law, without question, without compromise. The Japanese are obedient and submissive to that law which does not easily lend itself to the hocus-pocus of mitigation or interpretation. Among the chief characteristics of Japanese law, are to be found, philosophically, the traditional elements derived from Confucianism and feudalism.

Nevertheless, irresistible might and power are understood by the Japanese. They preach in effect that it is immoral to use force against a greater might. It is considered moral, therefore, for the individual to bend, to give, to yield, to the greater force; and, like the proverbial bamboo stalk, to give and bend but not break. Japan's moral consciousness is affected by propaganda, be it through education or religion. To the Japanese mind, it is not just a matter of foolishness to resist under such circumstances; it is *immoral* and lacking in sense.

Yet, the super-sensitiveness of the Japanese provides some basis for constructive social and political relations. Fair treatment, if coupled with stern justice, is understood and reciprocated. Courtesy is appreciated, especially if circumstances make it clear that no weak appeasement is involved. Japanese personal relations are based in socially individualistic feeling rather than in general principles.

Still another characteristic of the Japanese is their spirit of unity. Though they are ordinarily tight-lipped with strangers, they tend to spread rumors among themselves. They are essentially a propaganda-ridden people. They have little loyalty to American interests, but do comply now with directives and regulations specificially and definitely enunciated and promulgated.

The patriotism and the chauvinism of the Japanese are not simple; let us not overlook this fact. Their patriotism is deep, as profound as the Japanese themselves believe it to be; and they relate it to their concept of hero-worship with enshrinement of the souls of departed warriors. Too, there are in Japanese society patriarchal clans and groups. These are the *Uji;* with the *Uji No*

Kami, the high chief of the clan; and with the *Ujigami,* the patriarchal god, a clan patron saint. This grouping of clans into a faith is a pantheistic, animistic, nature-worship type of religiosity.

IV

The writer has indicated that the Japanese lack a sense of security; it is apparent, he argues, in their demeanor and conduct. The Japanese military cliques could not even think of losing, of retreating. The sense of insecurity of the Japanese has manifestations in other factors: They suffer an inward physical dissatisfaction based on their tendency toward flat facial features, ill-formed teeth, "feminine" chins, racial coloring, and an inferiority as regards size and recognized lack of good looks. Inwardly, they desire more western facial features. Nevertheless, as a "reaction formation," they possess a deep-seated sense of self-respect, of self-emulation.

In Japanese society, all children are taught from early years that life is fleeting, that the worthlessness of life is comparable to the fading of cherry blossoms. To the Japanese mind, life is not continuing or eternal in the philosophic sense. The western mind has predicated the schism of church and state; but in Japan the problem is the opposite: Unanimity of thought has existed for generations on this subject. The notion of Japanese *uniqueness* is actually a complex of ideas, mythological, unscientific; but such unfounded notions are easily accepted without question by the people. Such a traditional, religious, cultural ideology is prevalent in Japan today; but the fanatical and fantastic interpretations of Japanese history based on such thinking are slowly being modified; and the original concept of religion of the Japanese, *kami no Michi,* the way of the gods, is undergoing reinterpretations.

The matter of *hara-kiri* has been given much emphasis in analyses of the Japanese. But it is not to be overlooked that, basically, the Japanese—like all human beings—are predictable beings. In Japan there is constant problem of "face." The Japanese despise those who shame or embarrass them in the presence of subordinates. To lose face, is, for a Japanese, to have a fate worse than death, because it means loss of respect in all ways.

I further observed in Japan that even now the people are very ambitious and industrious. They seem to have an internal awareness of self-sufficiency. They toil and labor endlessly. Life to them is not avoidance of labor, as in European concepts. To the Japanese, there is an eternal virtue in labor; and they strain to accomplish missions, regardless of toil and hardship. (Perhaps this is based, too, on their inordinate and misplaced ambition to be superior, to surpass other peoples.) Despite the idealism of the country, the Japanese do act according to the human desire to earn money; in this regard, the Japanese, like all other peoples, are frail and materialistic, and find themselves easily engaged in inflationary activities.

On the surface the Japanese are stoical and unemotional. But this façade is a sham; for to them, a show of emotion is a disgrace. And their phlegmatism, too, is a fallacy; for they are violent, uncontrollable, when angered. Outwardly, the idea of control has been inculcated; but under their exterior, the Japanese *are* emotional, and are only steeled against any display of feeling. Their thinking is along family lines, and disputes are to be settled paternalistically. They yield—to compromise. But their paternalism is not a mental flabbiness or a desire to give favors, but is an attitude based on co-operativeness. The Japanese, among themselves, are required to obey because of a feeling akin to filial piety. Compliance is based on acknowledgment of their rights. To govern the Japanese properly, a consciousness of power is necessary; and those who govern or administer are expected to have the *capacity* to govern.

To lose one's temper in the presence of Japanese, is a cause for loss of esteem and respect. Theirs is a serious outlook on life. It is difficult for Americans to understand how very serious life is to the Japanese: to understand the ever-heavy problems of getting sufficient of life's needs, food, clothing, basic comforts of existence; to understand the intense competition among themselves in the fight against poverty. They lack true humor and have few real jokes in conversation. They fail in outward affection; and sublimation of their exterior emotions results in their use of personal diaries, which have in them flowery expressions of emotion and feel-

ing. (Witness the numerous published diaries of Japanese soldiers found in combat areas all through the Pacific.)

Especially significant psychologically, is the fact that there is great emotional instability among the Japanese after a period of suffering; and it is obvious today in Japan, particularly in the larger cities, that the people easily become nervously exhausted. The Japanese could readily be susceptible to mass hysteria. Another observation to be noted is that the Japanese of all classes like to strike theatrical poses and emit vocal sounds at times of stress or excitement or elation. They apparently think of themselves individually as participants in a historical drama and act accordingly with theatricality. Then they also have a conceptual attitude, called *Susano-o,* a kind of brother-relationship among themselves to the goddess *Amaterasu Omikami,* a swift, impetuous, male augustness. . . .

By and large, Japanese are an educated people, with an extremely high percentage of literacy. (Some investigators state this percentage to be as high as 98 per cent; but one questions whether rural folk were included in the statistics.) However, the fact must be pointed out that there is a vast difference between literacy *per se* and education. For the Japanese are at least 300 years behind the occident, educationally, in their ideology, in their viewpoints, in their attitudes. They have, it is true, a definite ideal of inventiveness, but at the same time they lack scientific knowledge and research techniques.

V

Though the Japanese may be slower in their thinking than some other peoples, let us not be deluded with the thought that they are stupid. They hesitate—only to make up their minds quickly at last. The reason is simply that they do not care, or choose, or wish, to commit themselves hastily. This attitude is reflected also in Japanese education. Today the educational policies of Japan are undergoing a modern inquisition because, for too many years past, they lacked scientific and philosophical principles and also relegated much Japanese history to mythological backgrounds. The Japanese stressed processes of indoctrination rather than the objective presentation of educational values. They used the word

Matsurigato interchangeably—for religious and educational rites and for affairs of state. Their irrational thinking was based on a process of propaganda and religious doctrines. They inculcated the ideals of the samurai cult, and used rote memorization in school courses, with an almost complete absence of creative thought in their pedagogy. Of course, much of their previous educational philosophy is presently undergoing revision under the military occupation of Japan.

There is, to be sure, no set rule or pattern to follow in any psychological problem of a broad nature involving a whole people—military government is in its operation essentially such a problem. Flexibility is most important at the outset if an organization is to run satisfactorily, as to its general principles. Changes must be made, but with time as the element. Despite propaganda to the contrary, much insecurity as to education still persists among the Japanese people.

Americans must remember always that we are dealing with a people quite removed from our way of life. The Japanese farmer-ancestors came to learn the value of patience in coping with the limited but persistent exactions of life. We must emulate in this regard the advantages and virtues of patience. Until the war's end, the Japanese had *carte blanche* trust in, and respect for, authority and what it decreed. America would do well to attempt at this time full democratization, as far as possible, of the Japanese mentality.

No people on earth has true love for its former enemy; and when circumstances make it necessary for one government or group of governments to control for the world's good a past antagonist, enforcement of regulations and directives must be based on impersonal, yet humane, law. Whether it be a military government or a civil affairs administration, there is absolute need for astuteness and intelligence in doing the job. The question is not one of soft-heartedness or hard-heartedness.

An intellectual approach must now be taken as regards the assets and liabilities of the Japanese, in our contemporary world-situation. We must not allow ourselves to be swayed by the mere slogans of the day about the Japanese: Bad and erroneous propaganda only breeds vicious hate and added misunderstanding.

A comprehension of the habits and outlook of any people is prerequisite to successful governance of them. Americans like to think that they act on reason; and the Japanese like to believe they move on the basis of feeling. It may be absolutely necessary to begin the control of the *feelings* of the Japanese. The approach of reason in the case of the Japanese, may prove ineffective; and rationalistic attempts to initiate amendments and changes in the Japanese way of life, may again prove of little consequence.

But the Japanese do have what may be termed a "sense of national gain." Military government is not operating in Japan, or anywhere else in the world, for that matter, for any gain whatsoever, either to the nationals concerned or to ourselves. It is the paramount job of post-war administration, both in Europe and in the Far East, to prevent future catastrophes of warfare. Military occupation has not, in its immediate province, the role of social uplift or of morale-building. Military government must not be carried out by super social workers with an eye only for the social scientisms of civilization. And it is to be remembered, I argue, that the complete obedience of Japan, as in the case of Germany, is absolutely essential and unequivocal.

Psychologically, the Japanese will not oppose the interests of their own country. If the people feel that by docile agreement they will speed the day of the end of the military occupation of Japan, it is to be expected that they will co-operate. "Unity of control" is now operating. Established relations, clear-cut policies, definite instructions, basic directives, proved principles, and absolute check and supervision—these are fundamental to proper functioning in Japan. Liaison must be clear and distinct, not contradictory.

To accomplish the objectives of governing a foreign country like Japan, it is necessary to supervise rather than to operate. It is best, then, to avoid direct administration, in order to have echelon-response from civilians who have both a strange language and a peculiar behavior. The military would derive the more benefit from not interfering unnecessarily with the over-all operation. Such functioning of the governmental structure must be accomplished, however, under direct and constant supervision. For any military government, properly understood, is not intended to re-

place existing government but to supervise and control it, to lead it into channels deemed sensible for the entire subject-nation, and ultimately for the welfare of the world. The prestige of native officials with their people should be maintained. Respect and official status, though at times ephemeral, are significant factors in maintenance of prestige. All direct orders to any foreign people must be tempered with common sense, and higher officials should be made responsible for the administrative functioning of their subordinates.

More, the present docility of the Japanese is a consideration worthy of thought. . . . As a philosophy of life, complete docility coupled with nonchalance is lamentable, for a people so imbued are too ready to put up with leadership of all conceivable categories, good and bad. The Japanese have a proverb: *Nakuko to jito niwa kanawanu* ("There is no reasoning with landlords and crying children"), and this sense of futility unfortunately has made them, for eras of history, easy marks for shrewd politicians and predatory usurpers of power. The present administration of government in Japan must determine not to allow *shoguns, daimyos* and other militarists ever again to twist the Japanese people into an unresisting mass of clay.

VI

The Japanese mind is intensive and complex: Let us not overlook this fact. Even the saving graces of democratic government can be overdone in practice, and our boasts of humane efforts and educational attempts may blind us to this fact. It is not for anyone to argue for inordinate restraints on Japan and its people; but we should be truly intelligent in our deliberations. Let us not forget that, while the Japanese island empire is both geographically and politically in some seclusion and has now a definite insularity, the Japanese as a people will never allow their heritage to diminish in intensity and accent.

The chauvinists in Japan must be made to understand—and for all time—that the end of World War II was a catastrophic defeat for Japan. The national political structure must be thoroughly reconstructed, and any plans of the chauvinists must be effectively frustrated. Above all, it is necessary to elevate the general culture

of the Japanese people as a whole; and Japan must be rid of her "warmongers' " machinery of repression. Japan can rise up as a cultural and intelligent state among the world's nations, if her system of education is overhauled.

For the time being, Japan's national structure and democracy may be considered compatible. From the standpoint of modern legal theory, democracy may be thought irreconcilable with the Japanese emperor-concept. But we should realize that in Japan's long history, the emperor has always been regarded as head of the national family. (Please note: I am not stating that Emperor Hirohito is blameless in the prosecution of the war. It is of no point here to discuss war guilt. I do argue about the principle of the emperor-concept as a tradition in Japanese governmental structure.) A modified democracy in Japan with an emperor as head of the national family, as the king of the British Empire acts as a symbol to his people, may well be in the true tradition of Japan, and serve as a pattern of future planning. The emperor might serve as a personification for national reverence.

However, the military in Japan—formerly entrenched in privileged positions, and constituting an *imperium in imperio*—must be completely deposed from power forever. If Japan has not yet awakened fully to the meaning of present events, the people should have unequivocal understanding of the political and economic changes now taking place in their country. Democratic ideas must filter down to the common man's level of understanding. From now on, the government of Japan must represent the will of the people.

Democracy will help break down certain of Japan's taboos, and will give expression to the voice of the Japanese as individuals. The people must be taught to grasp the very mechanics of voicing their will for definite aims and for political and social responsibility. Our job—the job of the entire world of nations who love freedom and peace—is tremendous, to be sure; but the possibilities for future peace are great; and America must not falter in the international vanguard. The occidental world must comprehend the oriental in the light of culture and societal structure. Perhaps our greatest postwar problems will concern themselves first with deeducating the Japanese, ridding their mentalities of the rot and ex-

creta of warped and twisted propagandas; then, with indoctrinating them with the semblance of intelligent and humane tendencies of civilization; and then, with re-education based on brotherhood and morality and humanity. America should long remember its Pearl Harbors, Tarawas, Saipans, Leytes, Iwo Jimas, and all other combat-fields, not as a determinant, however, of policy for the future in handling the Japanese, but as a guide, and selector-device, a source among many others for *understanding* the Japanese as a people.

It is to be questioned whether, essentially—because of indirect contact with democratic living by the Japanese—there may yet be in future generations in Japan sufficient reaction, to cause basic changes in Japanese law and culture. Obviously, there is today, in these postwar years, a consequent weakening of family solidarity; and contact with different social and religious systems will bring about a *consequent development* of critical scholarship in Japan.

But it is debatable whether the Japanese will ever accept *foreign* ideologies. Perhaps Japan has most needed in recent decades a cultural revivalism—that type of societal cleansing against which the Japanese long ago instituted an anti-foreign cultural bulwark.

Nevertheless, an analysis of the Japanese in terms of their psychology, indicates that as a people, they possess basic mental and psychological abilities, as well as thought-processes, similar at birth to those of any other peoples in the world. But, owing to a radically different system of training and cultural values, they interpret the essence of law and order in a fashion altogether unamenable to, and distinctly removed from, the American democratic philosophy.

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ART PRODUCTIONS INDICATING AGGRESSION TOWARD ONE'S MOTHER*

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The use of art productions in the treatment and interpretation of psychiatric states has been frequently described in the literature.[1, 2, 3] Art therapy is directed toward exploring the unconscious depths of the patient's personality. It is therefore concerned with the development of free expression in the form of spontaneous art as revealed in images and symbols, the language of the unconscious. What the patient dare not say in words or is unable to say, he can express on paper or in clay in the language of images. As the patient gains confidence in himself, his deep-rooted fears, wishes and fantasies, as well as repressions and unexpressed hates, are liberated through the imaginative forms of his art work. However, most of the work in this field has been done with hospitalized psychotic patients whose productions have been abstract and have required interpretation like dreams.

At the Curative Work Shop of the Veterans Administration regional office in New York City, only ambulatory patients are treated. While many of these are schizophrenic, they are either in remission, or their symptoms are so mild as not to require hospitalization. The writers have deemed it of interest to present a patient whose art productions definitely demonstrate marked unconscious aggression and hostility. Because of the good contact of this patient with his environment, he expressed these tendencies clearly and definitively rather than in abstract form. Moreover, these same art productions served as an outlet for the drives and thereby prevented the aggravation of the mental condition.

The following is a brief summary of his case:

X. is a veteran, 34 years old, of Jewish descent, who came to the clinic of his own accord, complaining: "I pass a store and after a few minutes, I have to go back and look again. I pass a piece of paper and then I am forced to go back and kick it. I leave the house

*The case presented here was studied at the New York regional office clinic of the Veterans Administration and is published with permission of the chief medical director, department of medicine and surgery, Veterans Administration, who assumes no responsibility for the opinions expressed by the authors.

and find it necessary to turn back to close a drawer or to see if I have closed it. If I don't do these things, I don't feel right. If I do it, I feel better." He said he had been sleeping fitfully, awakening and then walking the streets during the night. At one time, he found himself in Philadelphia. He knew where he was going but did not know why. He said his trouble began in July 1944, at which time he was in the front-line infantry and a barrage was being laid down on the advance of his unit. He felt his younger brother's arms around him and heard him say, "Don't worry. Nothing will happen to you. I'll take care of you." A similar experience occurred on three other occasions. The patient later learned that his brother had been killed in the Normandy invasion and that he had been dead at the time X. was undergoing these strange experiences. When discussing these hallucinations, he added, "I can hear with my mind." When talking about his compulsions, he used the phrase, "It told me to turn back, it told me to look again."

The patient was born on the lower East Side of New York City, the sixth of 10 children. He reported that the family atmosphere had been happy. His father was a furrier whom he described as "well known in the neighborhood." His mother was a hard-working housewife. Both were busy raising their family and paid little individual attention to the children. The patient was a poor student. He attended school to the seventh grade and left at 16 to go to work. Prior to the war, he had had various odd jobs, earning a maximum of $20 a week. He asserted that he had stayed on one job for six years. At the age of 12, he ran away from home and was picked up in the South for vagrancy and sent to a chain gang. The Jewish Welfare Society obtained his release and sent him home. At 16, he stated that he had found a handkerchief containing $116 and had set off to visit his sister in Cuba. On his return, he was arrested for stealing from a friend of his mother. He pleaded guilty and served four months in the penitentiary. He reported that he began to have sex relations at the age of 15 and said he had had such relations regularly until his military service but none since. He denied homosexual relations. He stated that he had been engaged to a girl but had broken off with her. How-

ever he added, "I will marry a handicapped girl who will appreciate me."

When first examined, he spoke about the "poems" he was writing and expressed the belief that he was a great poet. He also said he was able to tell fortunes. He believed that he could make predictions and was somewhat grandiose in his manner. He talked about donating to the New York Public Library books which actually turned out to be discarded pamphlets which he had picked up from a junk pile.

Psychological examination revealed an I. Q. of 98 on the Bellevue Scale. Verbalizations were peripheral, indicating a schizoid trend. The patient showed a drive toward grandiosity. His attitude toward his milieu was destructive. There was a homosexual coloration.

In later interviews, he elaborated on his difficulties. He began to complain that children's talking in the subway irritated him considerably. He felt "like going over and slapping them." He also claimed that a columnist of one of the tabloid publications had stolen a verse from him. He believed that he could write jokes, one of which was as follows: "I saw a man beating a woman on the street. I would like to give that man my wife's address."

At times, he felt that someone was hypnotizing him. His sexual inadequacy was symbolized in his dreams, two of which were as follows:

"Balls were growing from the side of my leg."

"A ball was growing from my back. I rushed to the hospital and someone put a needle into it and the ball collapsed."

He made predictions which always involved accidents. An example of this was as follows: "Last week I was walking along the street and thought, 'Someone is going to fall off the Empire State Building.' This happened a half-hour later."

The patient had to help with the housework, since his mother had recently undergone an operation for cancer of the breast. Nevertheless, he was afraid to stay at home lest he harm his mother. He stated: "The most important commandments are, 'Thou shalt not kill!' and 'Honor thy father and mother!' . . . As long as I stay away from home, I'm all right. . . . I often think of turning on the gas but then everyone would die. . . . I don't want

to hurt my mother, I don't want to hang around the house. I used to think about it—that I would injure my family by gas or fire. I don't want to be a burden to my family. . . . First I drew a clown, then I changed it to a skeleton burning in fire, then a woman screaming in fire."

The patient was referred to the Curative Work Shop to determine his aptitude for advertising. However, this occupation was ruled out because of his limited educational background. At the suggestion of the instructor, X. agreed to devote some time to a study of the principles of advertising design. He was referred to the art class for this purpose. At first, X. was reluctant to engage in any art activity on the ground that he had no creative ability. Nevertheless, the instructor succeeded in getting him to complete several drawings. When these were exhibited with the work of the more talented patients, he felt he had "found" himself in art and referred to himself as a master. The drawings dealt with somber subjects and expressed aggression and destruction. The patient was introduced to other media and finally showed the greatest interest in clay (in the form of Plastalene, a commercial product of clay in oil and wax). During the period from January 17 to March 27, 1947, the patient produced 11 pieces of sculpture. He also wrote interpretative verses for each one. The photographs of five of these with their accompanying verses are presented in Figures 1 to 5. It is to be noted that they all deal with the aggression of a snake with respect to a woman. The verses deal with the evil of women and the need to punish them.

The work of the patient might be regarded as creative in the sense that the objects produced were reflections of his inner conflicts, and as such were truly individual expressions of his emotions. From the standpoint of technique, the sculptures possessed a primitive quality. The patient applied color paints as an ornamental device to give a realistic touch to the sculpture in the same manner that the primitive artist used color to impart a life-like quality to his work. The application of color to the smooth surface added a decorative touch as well as it served to cover up imperfections in technique. The latter reason might explain the attraction to this device felt by this patient of limited artistic ability. From the first model to the last, there was no evidence of differ-

Figure 1

The Death of Beauty

Fangs of death upon her
Coiled around their prey
A lifeless body broken
When hate begins to play.

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A lifeless body broken
When hate begins to play.

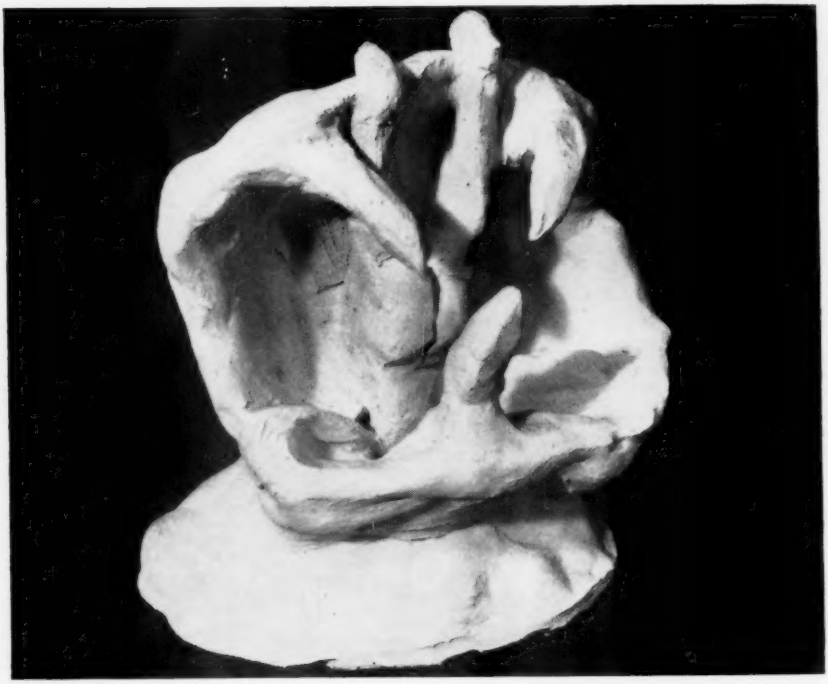

Figure 2

Cursing Sins

Her life on earth has ceased
For this will be her cell
Into the grave she took with her
The blessings of Dante's Hell.

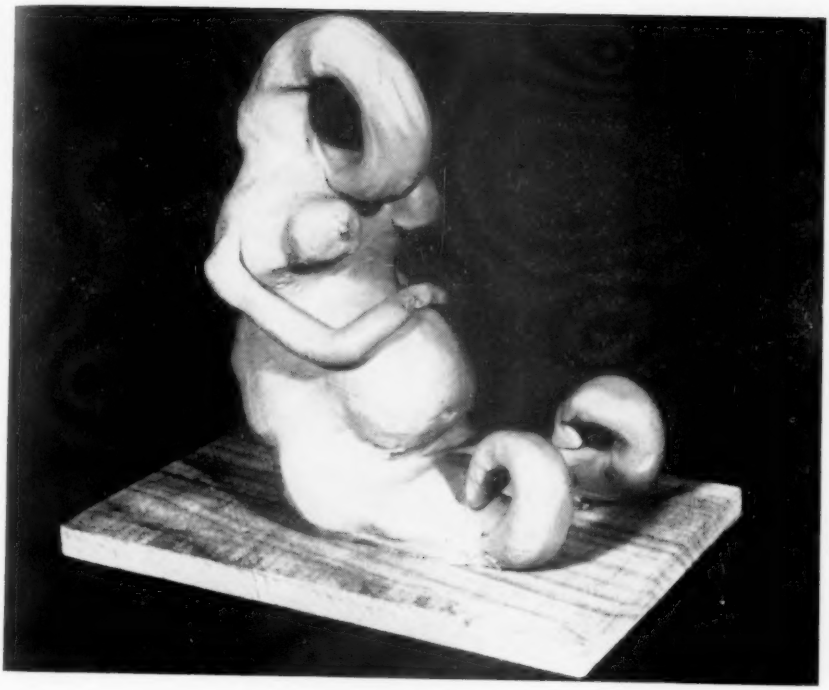

Figure 3

Blood of Fear

Her body filled with sinners blood
Into Hell will she roam
She put a curse upon her soul
For she will rot in the devil's home.

Figure 4

The Devil Attack

She played around with fire
Now blood flows through her heart
For she will die in torture
By the flaming devil's dart.

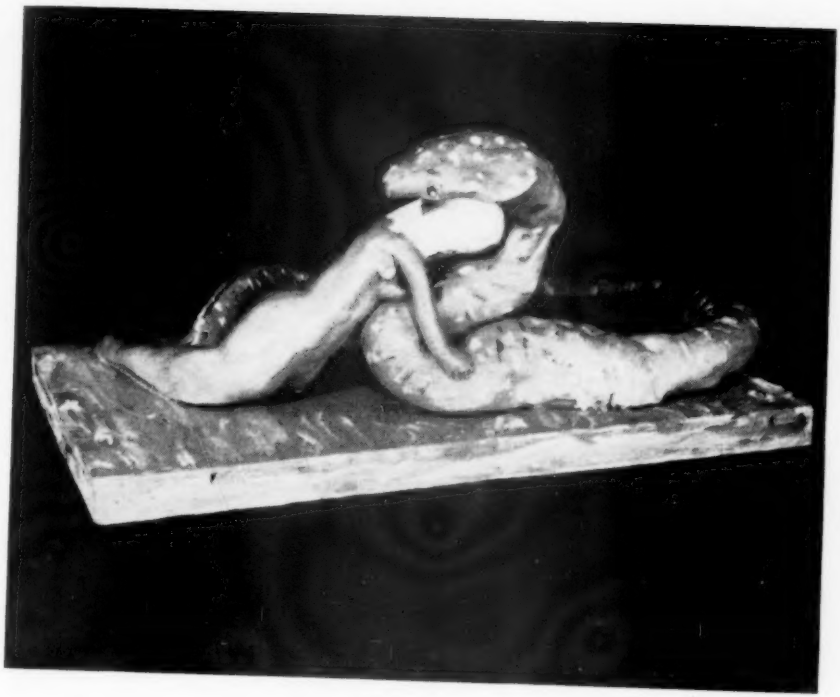

Figure 5

Guardian of Life

Protected by the fangs of the serpent
While beauty lies in sound sleep
Guarded by the king of reptiles
Her life is for him to keep.

entiation of form, color and subject matter to indicate improvement in technique. The art expression became set in a form characteristic of the man's psychosis. As a result, the arrangement and patterning of the theme were subordinated to the demands of his fixation. Any balance or symmetry was accidental since there was no advance planning of the steps to be followed in the execution of the theme. In general, the work of the patient could not be said to possess an aesthetic quality, either from the standpoint of subject matter or technique. X. had not obtained sufficient mastery of his medium to achieve a realistic representation of human anatomy. He strove for realism, but technical deficiencies limited his efforts to simplification. This simplifiication resulted in significant distortion of the body. With one exception, the sexual organs were not represented. Facial features were absent in most of the work. The mouth and head of the serpent were used to cover the female head. Another distinctive feature of the patient's work was the mutilation of the female by the serpent, a hooded cobra which he asserted he had seen in the Pacific islands. When he was asked why he modeled so many serpents and women, he answered, "I see it that way." As he continued his work in the Curative Work Shop, his ideas of reference and his beliefs in his being hypnotized subsided. His obsessions and compulsions continued. His tension appeared to be amelioriated, and his adjustment to his environment was more adequate. The aggressive traits expressed in his paintings also subsided.

Comment

The artistic productions of this patient indicated a marked aggressive trend which was directed toward women. It was not considered advisable to probe too deeply, but the mechanisms were fairly clear from the symptoms presented and the nature of the paintings and the sculptures. The patient had generally aggressive traits toward women and marked fears that he would injure his mother. He felt inadequate sexually, possibly due to some latent homosexuality. It was not clear as to whether he had ever made a heterosexual adjustment of any kind. He said that he had engaged in sexual relations but this could not be corroborated. He stated that he had broken off with his girl friend because he had

not wished "to waste her time." Actually, it was not at all certain that he had ever had a girl friend. It was definitely known that he had not had any sexual relations for eight months. His inadequacy was further demonstrated by the dreams about "balls" which have been mentioned and his statement, "I wish to marry a handicapped girl." With this inadequacy there was combined aggression, a desire to do away with the source of the inadequacy. This was manifested by his paintings, sculptures and interpretative jingles. All of these included a woman who was burning or a woman who was being tortured. Moreover, for a long time he dwelt only on the overcoming of a woman by snakes, a further evidence of his sexual inadequacy. X.'s symptoms pointed to the conclusion that most of his aggression was directed toward his mother. His constant fears that he would hurt his mother, his impulses to turn on the gas, his drive to stay away from home lest he do something "bad," and his statement that the only two important commandments were those relating to killing and honoring one's father and mother, all demonstrated his unconscious hatred of the mother. The patient had actually been carrying out his aggressions in his art work. His intense desire to be working all the time, opening up the shop with the custodians and closing it with them, indicated the strength of the drives. Undoubtedly, this work had satisfied those aggressive drives and in consequence, he had been able to make an adjustment outside a mental hospital. The decrease in the severity of the aggressive trends, as shown in his painting, pointed to definite improvement.

Summary

A case of paranoid schizophrenia with obsessive and compulsive features is presented. In his art productions, the patient showed marked aggressive trends toward women; and his symptomatology demonstrated fears of hurting his mother. It is believed that he carried out his aggression toward his mother in his art work and thereby obtained some amelioration of his symptoms and of his mental condition.

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THE TERROR AS A SYSTEM: THE CONCENTRATION CAMP*

Buchenwald As It Was

BY ERNST FEDERN (Prisoner No. 2402, Buchenwald)
Translated from the German by Margarete Hill Bruun

Democracy is like the air we breathe—we notice its importance when it is denied us. —MATEOTTI.

THE BUCHENWALD SONG†

When the days breaks, e'er the sun awakes,
The columns start out for the day's workout
In the dawn of the graying morrow.
And the woods are black and the sky is red
And we carry our breadsack and a piece of bread—
In our heart, in our hearts, only sorrow!
Chorus: O Buchenwald! forget you, if I could!
For you're my destiny.
He who has left you—he has understood
How wonderful 'tis to be free.
O Buchenwald! we shan't complain; through strife
And pain; whate'er our fate may be:
We shall, in spite of all, say yes to life,
For some day comes the hour, when we'll be free!
And the night is short, and the day so long—
Yet a song rings out!—a homeland song:
We'll not let our courage be broken!
Keep in step, my good comrade, keep courage, do not rest—
For we carry the will to *live* in our breast,
In our heart, in our hearts, faith unspoken!

*A Flemish translation of Mr. Federn's paper has appeared in *Ontwkkeling*, Antwerp. The paper was written three months after the author's liberation in 1945. Only a few editorial changes have since proved necessary; but the author wishes to note that he could not at that time consult or refer to the writings of others during his imprisonment. A further paper by him emphasizing the psychological questions raised by the concentration camps was published in *Synthèses*, Brussels, in 1946.

†Lyrics by Löhner-Beda who was killed by a drunken *Kapo* (foreman of other prisoners) in Auschwitz Concentration Camp in 1943. Löhner-Beda was the author of the lyrics for the operettas of Franz Lehar. The Buchenwald song was sung for the first time in January 1939, by the whole camp assembled on the parade ground. The prison orchestra provided the accompaniment. This translation from the German is by Margarete Hill Bruun.

And the blood is hot, and the girl far away—
And the wind sings low: "Oh, I love her so!"
If true she be, if true she stay—
And the stones are hard, but firm our stride—
And we carry the pick and spade at our side,
In our heart, in our hearts, love for aye.

I

Face Facts!

Immediately after the occupation of Germany, the propaganda first circulated by the foreign press gave to the outside world an impression which—although it did not convey anything false—presented an entirely insufficient picture of reality.

An excellent proof of how easily propaganda makes legends for itself, are the reports and pictures of the crematory in Buchenwald. Without a doubt, this crematory was a symbol for the terrors under which those incarcerated dwelt. It was more: It was a symbol for the regime of fascism itself. Even to the most hardened captive, the sight of the perpetually smoking and spark-spitting chimneys of the crematory was a warning, a threat of doom, a sword of Damocles. But, to be realistic, the crematory at Buchenwald was not a terrible thing. A city with a population of 40,000 and a mortality rate above the average needs such an installation. To show a large heap of bones and corpses is easy propaganda, especially in wartime. That the Nazi authorities did not take much trouble with the dead is surely a sign of barbarity; but if they had only treated the living humanely, their lack of reverence toward the dead could be more easily forgiven.

Nevertheless the reader will be interested in the history of the Buchenwald crematory. At first, corpses from the camp were transported to Weimar and burned there. But in times of the highest mortality rate this transportation of the dead could not be kept secret, and the citizens in Weimar began to mutter of the terrors of Buchenwald, without knowing much about the situation. In Weimar, the Ettersberg, on which Buchenwald was situated, was called "Totenberg" (Mount of Death). In order to avoid too much popular speculation, the decision was taken to establish a crema-

tory at Buchenwald itself. As far as I can remember, the building was begun near the end of 1939.

The crematory was operated by the inmates of the camp, and within its walls the gallows on which 12 persons could be executed at one time were also raised. More civil personnel and S. S. men were hanged there than prisoners. Prisoners put to death were usually executed by other means than hanging.

The cremation of a corpse takes about 30 minutes. The relatives were informed—often by telephone—in a very matter-of-fact way, and the ashes were sent to them, if requested.

At the beginning of 1945, when Buchenwald at times had 80,000 inmates, many of whom were brought there dying or with the mark of death upon them, the crematory could not keep up with the death rate. To make matters worse, there was no coke to keep the fires going. Only German "Aryans," among whom the death rate was low, had the privilege of being burned there.

The reaction to the reports on the terrible horrors that had actually taken place, is, in view of the false propaganda, also an unhealthy one. On the one hand, masses of people surpass each other in cries for revenge and damn the entire German population to extermination; on the other hand, people tend to become skeptics and say that everything is exaggerated, pointing to the large numbers who were able to escape. Thus conditions, it is argued, could not possibly have been so bad. In order to avert such unhealthy reactions in the public, the press must not, even in worthy intent, depart from the truth. This is because, as experience teaches us, every type of lie always carries with it a repercussion. In the present account it is unquestionably necessary to tell of things as they really happened, even if thereby many an easy explanation is exploded and many a political theory jeopardized.

This essay tries to show, and at least to some extent explain, the most essential fundamentals of the Nazi Terror, and how this Terror was practised through the concentration camps.

There were three types of concentration camps. In the first, the work which had to be accomplished was of primary importance, and those held captive there were, from a material point of view, well off. But no consideration was taken of the spiritual and mental make-up of the prisoners. With only such few exceptions that

they cannot be counted, the inmates could never speak with their families—even pictures of them were not permitted and could only be obtained secretly. There was nowhere a person who could or would help a tortured soul in trouble. From this point of view, every concentration camp was inordinately cruel. But, leaving the spiritual necessities aside, the prisoners in the first type of camp had a fair time of it. They lacked only freedom and the presence of their families. For a primitive, human freedom means the unhindered action of going where he pleases and freely disposing of his time. Both of these objectives could be attained by a large proportion of those living in the first type of camp.

In Buchenwald, the extent of one's freedom was as large as in a small city. And in the last years a non-Jewish prisoner had no reason to expect an injury from the S. S. In fact, if he had some ingenuity and knowledge of the camp, he could obtain clothing, see a movie, and even visit a brothel. In some of the large Type I camps there were radios, newspapers, and also excellent libraries. Hundreds of inmates were even excused from the very uncomfortable duty of standing during roll call, usually a very long procedure, which was undertaken in every sort of temperature and weather. Furthermore, during an air alarm, no one in all Germany was so safe as a prisoner in one of the better-known concentration camps. Food was good and sufficient until December 1944, so that many of those held captive were better off, in the matter of nutrition, than the average German. But all these facts were true only of those prisoners in Class I camps.

In concentration camps of Type II, things were very different. Here only a few lived as those mentioned in camps of Type I, and these few included either the camp functionaries, *Kapos* (who were foremen of the work commandos), *Bloc Ältesten** (prisoners in charge of individual barracks), or other overseers and clerks in the offices. All other prisoners were treated in such a way that they could barely stay alive, if they were healthy and competent at their work. There was just enough food to support life but these inmates were never without a feeling of hunger. Life was infinitely bitter. It was filled out with eating, sleeping—and

*Literally: "Barracks elders." These functionaries were prisoners in charge of two-room or four-room barracks. "Elders," of course, signified responsibility, not age.

WORK—not a minute left for anything else. Few could exert the intellectual strength, in the short period of free time, to do any reading or to engage in any mental activity. The joys of life were so infinitesimal that the life of an average prisoner in such a German concentration camp is inconceivable to one who has not experienced it.

In Type I camps only the more highly educated prisoner, and not always even he, was able to comprehend fully the proximity of the peril of death; to which, by the way, in Germany all were continually exposed. It is necessary to make an exacting analysis of the soul (which cannot be done here)* to understand the shocking fate of a normal prisoner in the Type II camp. The peril of death was continually staring him in the face, for there was only a short step from a Type II to a Type III camp.

Concentration camp Type III was a Hell. "Abandon hope, all ye who enter here." It is senseless to picture the atrocities in detail. Here the captives were anybody's game: The purpose of their existence was to be tortured and killed. There is no limit to human cruelty; and all sadistic lusts, which are usually known only to the medical specialist, could flourish in the Type III camps, the victims being the prisoners who had absolutely no way of protecting themselves. Crimes not only remained unpunished, but were often encouraged by the highest S. S. commanders.

"Your loyalty is your honor" was the motto of the S. S. That meant that every crime was justified by loyalty toward the Führer himself! The cruelties of past centuries were at least curbed by the religious precept of morality, and hangman and jailer were restrained by the force of public indignation. In Hitler's Germany the highest moral precept was not one of religion, or of a human ideal, but was one of loyalty to Führer and nation. Therefore, hangmen and torturers walked around in a uniform, which was designed to distinguish them in the eyes of the German people as "noble souls." But it is untrue to state that all of the German people accepted this swindle hook, line, and sinker. Laborers and workers everywhere, gave expression to their sympathy for the concentration camp inmates and to their hatred toward the S. S.

*See the present author's: *Essai sur le Psychologie de la Terreur. Synthèses*, 1:7 and 8, Brussels, 1946.

as early as 1938. Many members of the middle and lower middle classes also showed commiseration for the captives, though their expression of feeling was limited by their enormous fear of the Gestapo. In Type III camps, the S. S. had full opportunity to torture and murder, free from all moral or civil responsibility.

To understand conditions clearly, it is important to note that the various camps went through many phases. Each had its separate history, with its good and bad periods. Thus Buchenwald, from its founding in 1937 until 1939, was one of the worst camps, while from 1942 until its total disintegration in 1944-45 it was one of the best. Between the extremes of Class I and Class III, every camp ran the gamut of all imaginable gradations. Hence, any prisoner who had some luck, and the ingenuity to take advantage of it, might live on, and even live moderately well, for years. A considerable number of inmates succeeded in doing this. Here, as in the fighting forces, there were "tough" assignments and easy jobs, and there are always "smart" individuals who know how to obtain these easy jobs for themselves. But under the system of the Nazi Terror these privileged office-holders had no real security for they also were part of the system, and they might be liquidated without warning. Under Fascism there was no legal protection. "Right is that which aids the German people" was the motto of civil law; and as for public law, Goering had postulated that the Gestapo and the S. S. as well were not bound by any code of law. By this the foundation was laid for the unimaginable Terror which reigned in Germany and in which each category of political prisoner had his peculiar part to play.

In the camp even a prisoner in the best standing had the constant fear that he might be "demoted," and outside the camp every German (even in the S. S.) dreaded that he might be consigned to prison. Frequently S. S. leaders as well as their subordinates were dispatched to concentration camps, and even men in the highest posts were not immune or sure of their safety. Every one feared every one else. Children denounced their parents, friends betrayed friends, their only motive being the fear of being denounced themselves. An unthinking word could bring death by torture. Yes, it may be affirmed that, under the Hitler regime, Germans

were afraid even to *think* defiant thoughts, so great was the fear that gripped the population.

It is totally erroneous to suppose that a system of terror is strongest if all the subjects are under equal pressure. Such a condition would beget a reaction swiftly, and no government could resist it. Thinking of this sort has given rise to the widely-held belief that it is not possible "to sit on bayonets." On the contrary, it can be done, if not indefinitely, and it can be done successfully when the trick has been learned. Himmler and his consorts understood this—this, and nothing else. They were able, in a fiendishly subtle manner, to encourage some of their victims with privileges while dooming others at the opposite extreme to the most fearful fate. This system, which could be observed closely in the concentration camps, was also used elsewhere by wielders of power, but nowhere with such callous and calculating precision as the Reichsführer of the S. S. employed. The result was that those privileged, even in captivity, were nevertheless in perpetual terror lest they be suddenly hurled down to the Hell of Type III; and the most miserable souls in the lowest levels of Type III still clung to the hope that they might climb into a higher grade and so escape death. Thus *all* victims lived under inexorable pressure.

Only politically organized groups could have withstood this system successfully. But to organize such groups in a camp was exceedingly difficult. When the attempt succeeded, as in Buchenwald, it was achieved only through compromises with the S. S. at great spiritual costs and at the sacrifice of very many noble lives. Such groups could be built up by the captives who took over and performed some of the camp functions, but these captives thereby became, against their wills, the tools of the S. S.

It is commonly and mistakenly supposed that the Gestapo maintained the concentration camps in order to imprison political opponents. In reality, very few political objectors had the "luck" to be held in concentration camps. Such active anti-Nazis were physically destroyed or morally broken. The Gestapo made use of the expression "to stamp out opponents" and "stamping out" was achieved in a literal physical sense, or morally through full knowledge of modern psychology.

The majority of the camp inmates were not, therefore, people of political or intellectual importance, but plain, average citizens, and, mingled with them in varying degrees, anti-social and criminal elements. For no cause, persons in the Third Reich were sentenced to life imprisonment; often they had merely been "unfavorably noticed" by the Gestapo or by a member of the Nazi Party. It was the exercise of this terror against every one in the country which made it so effective. The Terror was the same in Type II camps; terror lay on every heart, for everything was forbidden, and every noncompliance with regulations was met by unspecified penalties and punishments.

Later, when so many foreigners filled the camps, conditions became slightly better. To comply with all commandments and prohibitions was impossible, if a convict wanted to live. Thus the first motto was not to be caught—not to be "noticed." That was the way it was also put by the S. S. camp leaders: "Don't dare get caught and don't you call yourself to my attention," these were the ever-recurring warnings by the commanders. An utterly frank code for criminals! As a typical example I might point out that in Buchenwald it was repeatedly forbidden to comply with the necessary bodily functions during the 12-hour work day—a cruelty and a method of terrorism which no propaganda has yet pointed out; and which shows so well what a hell even a Type II camp was.

The camp inmates were composed of all classes of people and were grouped in certain categories. Red triangles were worn by those incarcerated for political reasons; but that did not mean that they had necessarily been politically active. Any sort of vocal criticism, of mere disagreement, of pathological querulousness, or the suspicion of another-than-Nazi point of view, were enough grounds for one to be listed as a political prisoner. Those known as "allergic to work" wore black triangles. Black triangle wearers included all those who had been "noticed" through their work or positions; beggars and vagabonds; men who refused to pay alimony; in fact all who, according to the Gestapo, led an evil life without putting themselves at the disposal of the S. S. (It was still the safest thing in Germany to be a stool pigeon, or a member of the S. S., in order to avoid arrest, even if a membership in the S. S. did not offer anyone com-

plete safety.) Felons who had been condemned for criminal acts wore green triangles. Other prisoners who had been committed by court decree wore an "S" (*Sicherheitsverwahrung*) in the green triangle. Those suspected of homosexuality wore pink triangles. Jews who had consorted with "Aryan" women or were suspected of having done so were marked by a special tag. Jehovah's Witnesses had violet triangles, the "emigrants" blue ones; and Jews in general wore yellow stars as identification in addition to their appropriate triangles.

By order of the camp commanders the prisoners in one or another category might win preferential treatment, but most members of the S. S. had their special likings as well.

One S. S. man might secure for himself a following of Jehovah's Witnesses; another might surround himself with political prisoners, and so forth. The camp physician, Dr. Ding, preferred to work with Jewish prisoners.

He conducted the typhus station and had Jews working there to help him. This station used animals for experiments, which were scientifically conducted by a Cracow specialist, a Jew, Professor Dr. Fleck. In other stations, experiments on living human subjects were conducted in accordance with instructions by the government from Berlin, a fact which provides perhaps the crudest example of the consequences of fascism.

The name of Dr. Ding was the target of some misstatements which were printed in a Reuter's dispatch of June 30, 1945. By hearsay it was stated that a person named Schobert was a sadistic medical man who carried the nickname Dr. Ding. Schobert was the first camp leader; he was known by every prisoner in Buchenwald as a crude but good-natured man who did no more than his strictly-prescribed service duties. This error and some worse ones were spread because, after the camps were freed, some newsmen accepted uncritically whatever they were told by chance spokesmen and translators.

Camps of Type I were usually under the rule and management of political prisoners; but Type II camps were dominated by criminals and anti-social individuals. These persons were under orders, and were expected to maintain a mortality rate fixed by Berlin. Often it was rumored that Berlin had demanded to know why

there were so few deaths, and sometimes—as a contrast—that Berlin had objected because a death rate was too high. The extermination camps, Type III, were left, without exception, to the charge of the worst criminals. Sometimes the instruction to destroy referred to specific groups only; then it might happen that, within the same camp, thousands were done to death while other thousands lived quite passably. In such a situation the prison functionaries were in a position to transfer and so defer a sacrifice, thus snatching an intended victim from the very jaws of death. This happened frequently, and the concessions which political prisoners made to the S. S. were thereby justified in my opinion. In the course of years thousands of young lives were spared.

The character of a camp might be changed over night but only on order from Berlin. These changes usually came with the replacement of the camp commandant. Thus in 1942, Buchenwald became a camp of Type I quality, with the inauguration of Commandant Pister, because the flying bomb was to be manufactured there. There could be reversals of such improvements, and cruelties were perpetrated at the best of times. Every open complaint brought death or torture for someone, the penalties being inflicted apparently without any order from above. To soften them it was necessary to use diplomacy and discretion.

This leads to a further characteristic of the Terror system. The S. S. and concentration camps gradually developed their own peculiar customs and methods, rules of procedure which had been found effective and were endorsed by Berlin. But the application of these rules soon escaped the strict grasp of the Berlin authorities, and the monstrous corruption and unimaginable disintegration of the S. S. increased. Thus it was possible for leading prisoners to win a moderation of the brutalities in many cases, but the peculiar rules of the system also permitted many individual deeds of horror. In 1942, 12 Jewish masons were murdered because of the personal vindictiveness of a "*Rapport*" leader* named Hofschulte and the camp leader, Gust. Not until it was made clear that no orders from Berlin had authorized these murders, and that

*The *Rapport* leader was an important camp functionary, an S. S. officer. The word, "leader" (*Führer*) was used in the camps only in the titles of S. S. men. A prisoner who served as a camp official was a *Kapo* (foreman) or an *Ältester* (elder).

they were attributable to private initiative within the camp, could the deaths be halted.

Toward the end of the war, horrible outrages were made possible by the fact that the camp commandant was completely without means to feed and house the hordes of prisoners sent to him. The prisoners were unable to help where the power of the state proved impotent. The system of murder and terror swept into centers where Berlin—for political or military reasons—did not wish it applied. This happened in Buchenwald, where many types of ammunition and armaments of the greatest value were manufactured. Here the prisoners could accomplish much on their own. The S. S. camp leaders were satisfied to let the prisoners keep their own law and order and maintain half-way satisfactory sanitation. At the last, however, with the evacuation of territory as the allied forces penetrated into Germany, the orders from Berlin prohibited all measures which might have kept thousands alive. The chaos was beyond comprehension and produced the dreadful conditions which the Americans and British found, but which do not offer a true picture of life in a concentration camp in the years from 1933 to 1944.

To form a just impression of German concentration camps, the reader must reduce the common notions about the S. S. to something nearer reality. The S. S. formations went through varied phases of development in the course of years. At the very first, the corps had been composed of picked terrorists, fanatical followers of the Führer.

In Dachau the S. S. leaders split into two groups in 1938: one group wished the inmates to be treated fairly; the other favored cruel measures. This division created many possibilities of which the prisoners could take advantage; but it also created grave dangers. There were also decent elements in the S. S., but decent members lived under extreme terror and in even greater danger of denunciation by their own colleagues. An example from Dachau will illustrate this. There a block leader* who had always shown himself humane suddenly swung without cause or justification to furious methods, striking and swearing at the prisoners.

*An S. S. official in charge of a barracks. The prisoner "barracks elder" served under him.

Later we heard that this behavior, so uncharacteristic of him, had been displayed because too many prisoners had spoken of him as a "decent sort"; and in order not to be "noticed" by the authorities, he thought it best to assume the attitude of a brutal guard. The Terror was applied to the highest S. S. personnel, and even those who had been left without criticism for months might be put under fire at any time. The most secure were those who were the most bestial, and those who raised themselves to parasitic existences on mounds of corpses.

In the course of the war years the ranks of the S. S. were fundamentally changed. The young fanatics were replaced by older men, and ultimately the S. S. was recruited from men who were neither S. S. material nor National Socialists but were put into S. S. uniforms under compulsion or were induced to don them through false promises of jobs in Germany. Often such S. S. men were foreign-born Germans.

The story of Peters, the leader of a construction unit, will serve as an example. He was one of the few really decent men in S. S. uniform, and the account of how he came to wear it is entirely credible. He was an ordinary soldier from Upper Silesia, not a member of the party, even more sympathetic toward the Poles than toward the Germans. A mason in civil life and the father of four children, he had been decorated for bravery in the army several times. Then he was taken to an S. S. hospital severely wounded. Coming out of the anesthetic, after the amputation of one of his legs, he was persuaded, while still in a daze, to join the ranks of the S. S. In these circumstances he felt there was little hope for him if he refused. "And so I became an S. S. man." His is but one of many examples. So badly disintegrated did the S. S. become that a *Rapport* leader named Werle asked one of the prisoners in a work group to keep watch over the sentry. These signs of disintegration encouraged the prisoners to withstand the S. S. brutalities as successfully as they did until the Americans reached Buchenwald.

Certainly S. S. morale varied in different camps. In Bergen-Belsen and in like camps, where the most bestial types were in control, the situation of the inmates was much more desperate than in Buchenwald where Commandant Pister limited the severities

as far as possible to those ordered from Berlin. Many propagandists do not welcome the truth that thousands of prisoners survived through the intervention of individual S. S. men, while thousands of other prisoners died because their fellow-inmates, often those with political functions to fill, neglected their human duty. But these facts are part of the truth.

It can be easily understood that from the time of liberation distorted news was published and used for propaganda purposes. That procedure should be avoided. Truth is a sufficient witness against the criminal Terror of fascism. Falsification in one sense creates more falsifications in the opposite sense and blocks the way to the "conquest of this tragedy." In cases like that of Pister the restoration of the facts is possible, however far I am removed from any attempt to shield officers of the S. S.—with one or two exceptions. On the contrary, I believe, like most former political prisoners, that *all German officers and all leading civil servants* are collectively responsible for the crimes of the regime. But this is no excuse for spreading misinformation, be it whitewash or false accusation.

A Reuter dispatch from London, June 30, 1945 affirmed: "It is announced that Hermann Pister, 'the Beast of Buchenwald,' has finally been captured. He was discovered, along with eighteen of his collaborators, in a prisoner of war camp in Bavaria, where he had passed himself off as an officer of the Wehrmacht. All were provided with false papers which they had compelled Jewish prisoners to fabricate a few days before the liberation of the camp. Pister who was in command of the camp during the last eighteen months of the war, bears the responsibility for the worst horrors which were perpetrated under his orders, notably the injection of poison into the veins of incapacitated prisoners. He succeeded the infamous Koch whose wife collected lampshades made of human skin. . . ."

Never was Pister named "the beast" by the prisoners. The truth is rather that he was called the "good commandant" when he took charge of the camp in January 1942, because he attacked corruption, very much softened all punishments, and conducted an easier regime and lighter treatment for the Jews than any previous commandant had sponsored. Of course, no Jewish prisoners

in Buchenwald where Commandant Pister limited the severities

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were compelled to manufacture false papers for him; Jewish prisoners could not have done this; and Pister had no need of it, since like many high ranking S. S. officers he also belonged to the German army. He would not have had to have recourse to any biased testimony, because he could have appealed to the leading prisoners of the camp, among whom he had an excellent standing, since all knew that only his sabotage of orders from Berlin made it possible for the Buchenwald prisoners to survive and to await the Americans. Furthermore it is untrue that Pister was responsible for the poisoning of "useless" prisoners, for these poisonings were carried out in every part of the Reich under orders of the National Medical Board (*Reichsaerzteführung*) and of the National S. S. command (*Reichsführung* S. S.); in public hospitals also, patients were poisoned.

In the camps not only the officials but also the political prisoners themselves applied poison to dispose of individuals who were condemned to death by prisoner courts of justice. Among themselves, prisoners could not proceed in accordance with the basic principles of justice in democracies; they secretly used their personal, however arbitrary, judgments when a fellow-prisoner was "indicted" and the verdict was passed.

When we assemble these findings, we note that the camps were founded on the principle of "divide and rule." The S. S. was divided itself, split into factions. The prisoners themselves were divided into three categories: (1) the privileged; (2) the work slaves; and (3) those doomed to extermination. This triple partition made possible, on the one hand, the most terrible brutalities; and, on the other, made it possible to save some victims from their doom.

II

Terror Against the Jews

The face of the Nazi Terror can only be read by not simplifying its complicated nature. While looking at each feature separately we must endeavor to recognize its dynamics and dialectics, and not content ourselves with statistical description. That means one must look at the manifestations of the Third Reich objectively. At that point it becomes apparent primarily that the most important

feature of this terror-regime was its secrecy. The word Gestapo stands for *Geheime Staatspolizei*: secret national police. The word secret ought to be underlined three times and capitalized.

Like the medieval *Feme,* and the American Ku Klux Klan, the S. S. was covert. The difference from the other dictatorships lay in the fact that the Nazis had discovered that a *secret* Terror was so much more effectual than an open one. The latter may discourage, arouse fear and anguish, but it also antagonizes and brings out counter-pressures, opposition, and defense by its victims. Secret Terror is as frightening as a slowly advancing disease, as a deadly bacillus which one cannot see. A paralyzing fear lay upon the whole German people because no one really knew precisely *what* was happening in the concentration camps. Herein lies the key to one of the difficult problems: Germany itself. The Germans, and later all the peoples of occupied Europe, knew only this: that, constantly, individuals here and there vanished, damned to some uncertain and terrible fate. But what that fate was no one could say with certainty. Civilians sometimes witnessed the harsh treatment visited upon prisoners. But the S. S. took care that such leaks of information were not published; the newspapers continually reported that only the very dregs of humanity were imprisoned in the camps, and that none of the inmates deserved even the food they ate. During the inspection of the camps, the same justification was offered, and new S. S. men were instilled with this doctrine. It always took considerable time to convince new supervising officials that there were others besides criminals incarcerated in Buchenwald. When incoming wardens convinced themselves of this, most of them changed their attitudes toward the inmates.

Experience suggests that the people living in the democracies underrate the power of lies and the amount of moral pressure under a totalitarian regime. The present Pope declared when he was papal nuncio in Berlin, "National Socialism is the Lie become Flesh." That is entirely true, but it should be more emphatically stated. For the lie ruled everywhere, in the radio, in the daily papers, in private intercourse, everywhere lies, lies, and again lies! There is a saying that lies have short legs but in politics propaganda gives them stilts. The average citizen, at first, is un-

able to believe it conceivable that lies could be so brazenly circulated. When he discovers the deceit, it is too late. This tragedy was repeated in all the totalitarian countries; and all imposters through the ages have used the same deceptions to enmesh their victims who are unvariably taken in by similar political propaganda. The failure of foreigners to estimate the moral and spiritual terror abroad in Germany was a primary factor in their failure to understand the German situation. In the occupied territories the moral terror was less acute; and resistance, for a number of reasons, remained stronger and more enduring.

Even in the later stages, when laxity and slovenliness infected the S. S., one rule was maintained with vigor: To speak of barbarities, murders or other crimes meant death for all involved. This principle was inexorably applied. Even the prisoners spoke of such matters with extreme reticence—with more caution than they used for such dangerous topics as politics. To criticize political issues with an S. S. man or a civil guard was safer than to breathe a hint about the brutalities of the S. S. Perhaps the world will understand the German people more readily and condemn them less when it learns that every prisoner, when asked the question, "How are you?" answered, "Very well. I have nothing to complain of." Care was taken that only fairly healthy-looking prisoners came into contact with civilians from the outside. Just how intense the terror of violating the conspiracy of secrecy was, I shall explain by two examples of what happened in Buchenwald.

While assigned to a labor detachment of 30 Jewish prisoners, the Viennese film producer, Hamber, was drowned in a pond by the S. S. troop leader Abraham, in the summer of 1941. When the unit returned to camp and questions were asked regarding the disappearance of the prisoner, his brother related the facts of his death. When asked if there were any other witnesses, the brother answered, "Everyone saw it." His companions offered no comment. The officer making the inquiry said nothing more. Two days later the brother of the murdered man was himself arrested and done to death. During the following two months *all* 30 prisoners who had witnessed the crime were poisoned. The S. S. guard responsible for the first crime was investigated for the sake of appear-

ances and then advanced in rank. He was a sadistically-inclined psychopath.

Here is a second example: A Jewish prisoner collected wood one evening after work, in order to exchange it for food. By chance his search took him to the place where Russian prisoners were shot. A patrolling S. S. man saw the Jew and took his number, although his actions were obviously innocent; and, at that time, collecting wood was punished at worst by a beating. The next day the Jew was arrested and killed by injections. This Terror was not applied only against Jews however. No one, on pain of death, was ever allowed to make any reference to the medical research carried out on the prisoners.

In spite of the censorship, through carelessness, a few isolated items on these horrors came to the knowledge of the civilian population. But fear was so widespread that civilians were afraid even to listen to such reports, let alone repeat them. When it is realized that the clouds of smoke from burning corpses sometimes covered the city of Auschwitz for days, is it surprising that a people exposed to such a Terror felt a paralyzing fear seal their lips? Why did not the Swedish envoy, who was under the protection of international law, challenge Herr Himler's statement, when that greatest criminal of history cynically implied that the gas ovens of Auschwitz were used for disinfecting purposes? The Swedish diplomat preferred not to argue with Himmler. Did not the outside world close its eyes to the revelations of *The Brown Book, The Rubber Truncheon,** and publications of German exiles from 1933 to 1939?

The Nazi leaders had guessed correctly; a secret Terror which commits cynical crimes and denies them with equal cynicism is much more effective than the public trial and extinction of enemies. The invisible Terror was the original inspiration of Himmler, and his reasons can only be surmised, for he took them with him to the grave. It need not be too difficult to understand why a people like

**The Brown Book of the Hitler-Terror and the Burning of the Reichstag.* A. A. Knopf. New York. 1933. *The Rubber Truncheon, Being an Account of Thirteen Months Spent in a Concentration Camp.* By Wolfgang Langhoff. E. P. Dutton and Co., Inc. New York. 1935. (English translation of *Die Moorsoldaten,* literaly "The Bog Soldiers," from the large bogs of northwest Germany where many concentration camp prisoners worked.

the Germans needed such a system of Terror in order to put them into the condition in which the nation finds itself at the present time. For the higher the culture of a people, the more terrible the methods must be to throw them into such an abyss.

The Jews played a deciding role in this Terror-system. No people on earth, no prisoner, has ever led such a life or suffered more wrongs than a Jewish prisoner had to bear in the Third Reich.

The Nazi Terror, in its development, paralleled the phases of similar social movements. There can be no doubt that the Hitler regime lost more and more of its inner dynamic power as time went on; and, therefore, it became increasingly necessary to intensify the Terror. On the other hand, the S. S. had to take all sorts of matters into consideration. Because of an extraordinary shortage of laborers, the military chiefs and the economic administrators finally had to take measures to prevent the senseless destruction of able-bodied persons, efforts which were never wholly successful because this fathomless Terror was the very foundation and sustaining force of the Nazi power. At the end of the war, the total disorganization, hastened by the advance of the Allied troops, and by the terrible bombing raids, spread such chaos that thousands of prisoners died wretchedly because the German authorities did not have the necessary housing facilities, the food, clothing, medical supplies, or means of transportation to care for them. This was the explanation of the gruesome conditions which the invading troops found on their arrival. The Buchenwald Camp commandant's excuses for the wretched conditions are well answered, however, by the indictment uttered by the Danish delegate of the Red Cross who protested at the state in which Danish prisoners were found: "You must not make war if you have not the wherewithal to care for people decently."

Officially, no one could help the Jews, even though private organizations and some army units treated Jewish skilled workmen considerately. In Buchenwald the Jewish masons and other Jewish specialists were well handled by the camp commandant. Whenever, again and again, anti-Semitic orders were carried out, it was because the S. S. was too weak to impose strict measures upon other than Jewish categories among the prisoners. In the last years at Buchenwald, however, the S. S. came under the rigid con-

trol of economic and military authorities. But anything was allowed against the Jews—for in the eyes of Nazi officialdom, they were the cause of the war, and no one dared offer them protection. In Germany the Jews were considered outlaws, without protection of law, and at the mercy of every criminal. Thus it was that the Terror in a concentration camp worked first of all against them. Certainly there must have been other camps in Germany where the Terror raged against all persons of all nationalities equally. But in the well-known camps it was only the Jews who were constantly at the mercy of the Nazi criminals—always before Jewish eyes the dreadful threat that "no European Jew shall survive this war," as Goebbels expressed the Nazi determination. Aided by this anti-Jewish Terror the German government threatened all people in Germany and eventually all of Europe. This was understood by all nations. Often the privileged prisoners, against whom no severe measures had been taken, felt the full implication of the system when they heard of some special decree against the Jews, and muttered, "You today; we tomorrow."

We can understand the fearful crimes which National Socialism has committed much more clearly if we understand that they were planned by cool minds, and if we recognize that anti-Semitic propaganda had a special function in this task. This propaganda was intensified by mental conditions and its effects were magnified; but the fundamental motive for Hitler's Jew-baiting lay, I believe, in his political policy, which was founded upon a refined and carefully-thought-out system of intimidation. Unfortunately, the Jews living outside of Germany, in Europe and abroad, did not recognize the true state of affairs in time.

The Terror against the Jews was slowly extended to ever-increasing numbers of people. At the outset, the concentration camps were reserved in the main for those Jews who were leftists. Such Jews (the few exceptions prove the rule) carried on their fight as worthy political gladiators, but most of them, and these the worthiest, were annihilated in the course of the years; and very few have survived.

The next type of Jew to come under the Terror was made up of the more or less criminal elements. The *"Ringvereine"* (members of a German underworld organization) were hauled into the camps

years at Buchenwald, however, the S. S. came under the rigid con-

in large numbers. These Jewish criminals behaved exactly like other criminals. But one must not overlook the fact that the most hardened criminal, in the opinion of modern criminologists and reformers, does not merit such punishment as a life term in a German concentration camp. This does not alter the circumstances or cancel the evidence that some Jewish criminals, like the felons from other countries, became the instruments of the S. S. for years and outdid the atrocities of the bestial S. S. themselves. It has become the tragic fate of the Jews to meet an attitude different from all other peoples, and the crimes of a few are often laid on the backs of all. In the course of years such Jewish criminals as were guilty of atrocities were sentenced and executed by decision of the prisoners themselves, in so far as the S. S. had not already settled their fate; by 1941 the majority had been asphyxiated in the gas chambers. In all fairness, it must be noted here that among the Jewish criminals were some who, in camp at least, always behaved decently, and showed a character superior to that of quite a few of the political prisoners.

The third category of Jews who were singled out under the Terror were those who had been born in Poland but had come to live in Germany. The cruel measures, applied earlier after the annexation of Austria and during the reprisals ordered when the German Consul Rath was assassinated in Paris, had already proved that the masters of the Nazi Terror did not draw the line at seizing "non-political" and "decent" Jews. Yet despite such indications, foreign, like German, Jews were caught by surprise as the Terror spread. In any case, it was very difficult to leave Germany and escape by a legal method. Of the Jews brought into the camps, most revealed remarkable tenacity and ingenuity, proving that human beings preserve their characters even in the greatest distress.

By far the largest number of victims was taken from among Russian and Polish Jews. The former were murdered without exception, if not in Russia, then later at the liquidation centers of the S. S. Only a pitiful remnant were able to disguise their Jewish origin and so save their lives. A different fate awaited the Polish Jews. Some of them showed remarkable moral and physical stamina, and many were dispatched to the camps as skilled laborers,

with the result that the younger in particular often preserved their lives. A large part of these became tools of the S. S. I regret to say that complaints about atrocities perpetuated by Polish Jewish prisoners in the camps of Auschwitz, Lublin, and other places are justified; but one cannot ascertain how many of these crimes were committed by persons who already were criminals. Furthermore collaboration with the S. S. was committed by prisoners of *all nations;* this fact constitutes one of the most melancholy chapters of the story of the camps.

At the very last the Terror raged against the Jews of Western Europe. Those who were not killed immediately had the easiest lot among the Jews in the camps. Yet their fate was harsh for all that; and they suffered in particular from the severity of the climate and the lack of footwear. The weather was one of the most deadly allies of the S. S. How bad conditions in a concentration camp really were, citizens from western countries did not know; for, by the time they began to arrive, the worst times were past. Those who were not dispatched to extermination centers, but to Type I or Type II camps could survive with some power of resistance. The horrible, sadistic excesses which had been daily events in the years 1933-41 no longer characterized the work camps. Other centers—Auschwitz, Nerzweiler, etc.—had been established as extermination holes. It is a fact that the life in a concentration camp was harsh and cruel to a "spoiled" Western European and that all the weak and sick died. When we consider that in Dachau, between 1933 and 1938 the prisoners were allowed to move about only at a dog trot, that the most insignificant misdemeanors (like putting hands in pockets) called forth the cruelest punishments, that anything and everything was done to make one's very existence painful; that all labor was accompanied by beatings, then the prisoners from the west must admit that they had a better time of it than the German victims who had been imprisoned many years before the war. These had to become toughened in order to stay alive. The German political prisoners had passed through very bad times indeed before they became the supervisors of their comrades from the west.

This short sketch shows how various the persons were who were exposed to this unbelievable mental and physical Terror. Being so

differently constituted, they reacted in various ways. You could see in the prisoners of all nationalities examples of the most heroic courage and admirable resistance, side by side with deplorable and wretched behavior.

The Jews played a distinctive role in the system of National Socialistic terror. Whenever the S. S. massacred the Jews, other peoples were also overcome by fear. The atrocities against the Jews also terrorized those who were not exposed to them. The Jews were the food on which the S. S. beasts throve, they were needed by the Hitler regime for carrying out its political plans. Goering once bluntly said that without concentration camps the Nazis could not carry on their government. The situation was the same in the camps themselves as in Germany in general. In the camps, the Jewish prisoners were scapegoats who were punished whenever the other prisoners could not be punished because of weaknesses in the S. S. The procedure was: "Who is to blame? The Jew!" And just because this pretense is primitive and stupid, it was effective among large circles of the lower middle classes. Certainly it was always the Jew who had the worst of it even in the best-run concentration camps. In Buchenwald, the fate of the Jews was not softened until 1944.

Aside from physical fear, the moral terror to which the Jews were exposed was even worse. A Jewish prisoner was considered the lowest category of man in Germany. An "Aryan" gangster-murderer was a step above him in the social ladder. Yes, even an animal was worth more than a Jewish prisoner. The Jews who were forced to pull the work carts were treated incomparably worse than the horses which replaced the prisoners after 1942—because in the eyes of the S. S. a live horse had a buying and selling value, whereas a dead Jew was worth more than a live one. The reader of these lines will have to use a good bit of imagination to put himself into such a situation. Let us consider that a Roman slave, at the least, was valued at the price which had been paid for him; or, at the worst, he was a prisoner of war and was despised as a barbarian. But the Jew was, according to the propaganda of the state, the originator of all the state's ill luck and misery; each individual Jew was expected to atone for this; and the whole group was sentenced by Hitler to death because of its

abominations. It was always permitted to kill or torture a Jew; and if there were times when the Jews could live passably, it was only because in the final years Nazi propaganda did not make any impression—even on the S. S. In spite of this, shorter or longer epidemics of pogroms broke through the apparent quietude. Every Jewish prisoner, even when he was passably well off, was a pariah without recourse to justice; was already sentenced to death, and was required to bear in mind continually that he was slated for death. No one else had to bear such psychic terror. Indeed, every prisoner was in danger of violent death without his murderer being called to justice, but only the Jews had been singled out by the government itself to be exterminated as a whole. At one time, Polish prisoners were severely tormented and declared to be morally degenerate, but that stage did not last long. Thousands of Russian prisoners of war were shot; but *all* Russian Jews were murdered.

In spite of this, thousands of Jews managed to offer resistance to the Terror. Hundreds were able to gain positions of trust by their workmanship and ability, and to keep them for many years, thereby resisting anti-Semitic propaganda by their individual behavior. The Jewish prisoner, along with all the martyrs of all nationalities, has shown the world what inner strength to resist can accomplish, and that the old song is true which says: "For they cannot kill the spirit, oh, Brethren!"

III

Camp Psychology

The most important instruments the S. S. found for their criminal projects were the criminals among the prisoners. Modern psychiatry has shown that the criminal is an individual whose emotional development was arrested at a primitive stage. Such individuals may be tempted to infamous acts as easily as a child. They are dominated by elemental urges and their sense of discrimination between good and evil is lost. These factors make fitting servants of the S. S. terror system. This was proved by years of experimentation in the concentration camps where the criminals were vested with the power of potentates. The crimes committed by such persons must be laid at the door of those who invested them with the power of life and death.

The intermingling of criminal and anti-social elements with prisoners of high moral, mental and social gifts was one of the peculiar horrors of the terror system. The fury let loose by the vilest criminals, pimps, murderers, sexual perverts and alcoholics was a primary factor in the terrible atrocities of Camps Mauthausen, Gross-Rosen, and Nerzweiler, and the centers in Poland. Most of the time the S. S. allowed the atrocities to be committed by professional felons; the S. S. men themselves participated in deeds of horror less often than is commonly supposed. In fact the number of depraved characters in the S. S. was small in comparison with their power and influence. A very few, sadists without conscience, held thousands of prisoners and even their quiet-natured fellow-S. S. men in subjection, because these brutal individuals were protected from above. Every objective estimate of the situation leads to this same conclusion: The responsibility for the crimes perpetrated lay with the German government rather than with the instruments who carried out the instructions.

Wherever the "Greens," or criminals, were not managing the camps, the political prisoners, the "Reds," were in charge. In all the prisons, the S. S. only observed the running of the camp, leaving the routine management in the hands of the prisoners themselves. This procedure permitted camp functionaries to obtain great power and influence. In Buchenwald, for instance, the weight of influence that lay with the leading prisoners often was greater than that of the S. S. themselves, for the prisoners frequently were trusted more than the S. S. by the commandant and the director of the camp. Such a situation could place political prisoners in a difficult position. To avoid incorrect judgments, it is important to analyze the implications of these developments.

As it has already been pointed out, the misconception, held even in well-informed circles, that the concentration camps were founded for political prisoners is incorrect. It is true, of course, that some brilliant and important leaders of the left wing parties were liquidated in such camps—the list included celebrities such as the poet Erich Mühsam; the president of the Prussian Reichstag, Ernst Heilmann; the former Communist deputy to the Reichstag, Werner Scholem; the Vienna city councilman, Robert Danneberg; the Czech deputy, Emil Strauss and others. But most of the leftist

leaders met physical and moral death outside the camps, or were destroyed inside the camps but not by usual camp methods. Prisoners who had been truly "politicals" were always a minority in the camps, that is, if one excepts inmates from Western Europe who were almost all involved in the resistance movements. But these latter did not begin to fill the prisons until 1943, 10 years after the inauguration of the camps.

Among German political prisoners, not more than 10 per cent had held positions of responsibility as party functionaries. With few exceptions they kept away from every camp administrative duty, preferring to work secretly through the prisoners' organizations. The few who did undertake administrative tasks did so only because of their special qualifications and abilities, and almost paid with their lives for their loyalty to their political convictions. Most of the higher offices were not filled by men who had given evidences of leadership qualifications before incarceration.

The problems confronting a responsible camp official were extraordinarily difficult. A *Kapo,* for instance, might head a work battalion of 1,500 prisoners. A barracks elder might have charge of a barracks of 500, 800 or, during the last months of the camps, over 1,000 inmates. These two types of "officials" had to follow the orders of the S. S. on the one hand, and on the other try to be faithful to their roles as political prisoners. They themselves were imprisoned for years and suffered the same spiritual pressure as all other captives. To be sure, they were spared the more oppressive and more wretched conditions of the camps and could even obtain some luxury for themselves. But privileged rating and greater material comfort naturally made it the more difficult for them to maintain correct moral attitudes. The positions of responsibility which prisoner "officials" assumed became too coercive for most of the political prisoners who undertook such jobs. For obvious reasons, they hated to renounce their privileges, and thus they slipped into compromising situations. Such ambiguous figures and untenable roles always find expression in concentration camp life, and sooner or later will come to light. To "whitewash" them would be neither practical nor morally justifiable. To be honest about conditions and to describe conditions as they actually were is the goal here.

It is regrettable but true that most of the prisoners who served as "officials" were hostile against the Jews in their thoughts and their actions. The terrible treatment of the Jews and their heroic endurance were less regarded by their fellows in power than were what were considered as more objectionable Jewish characteristics. Nearly all "officials" permitted more violence and beatings than were necessary, or even efficient, from the point of view of camp welfare. In bad periods at Buchenwald, beatings could not be entirely avoided, because, from time to time, savage elements had to be brought to reason. Had they not been, other prisoners would have been endangered by the violations of the rules and the disobedience of a few. It is likewise a fact, regrettable but not to be gainsaid, that political prisoners preferred their fellow-countrymen to foreigners. Once again it must be emphasized that a majority of the prisoners confined for political reasons (some small groups excepted) refused to identify themselves with any intellectual or spiritual stand, even though in Buchenwald it would have been possible to promote and share activities of the mind.

Camp political life was poisoned, however, by ridiculous conflicts between different factions, feuds which sometimes led to the actual destruction of opponents through the aid of the S. S. Furthermore, personal contacts and regard for humanity were maintained among the political prisoners with the greatest difficulty, because their fathomless sexual cravings cannot be imagined by those who enjoy freedom. The insincerities and inhibitions which mark the attitude of most men in sexual matters led in camp also to manifestations of extreme hypocrisy and concealment which poisoned the whole atmosphere. The establishment of a brothel was merely a device of the S. S. to bring all urges within the scope of the Terror; and the presence of women—even prostitutes—sped the moral disintegration of the prisoners. Furthermore, many German anti-fascists could not resist a handsome boy, so that homosexuality claimed its sacrifices by degrading life and character. These are the sad facts. And even though these facts reduce the picture of the concentration camp from a stark black and white to a grayer world of compromises, the reality remains no less an indictment of the Fascist Terror: It is not an indictment

of the victims. Existence in the camp was so unbelievably hard that only a chosen few could pass time there and remain without stain. Moral and physical stamina, united to a strong and well-founded character, were necessities if a man were to remain loyal to his duty as a political independent for 10 years or more. Men with such outstanding characteristics could escape death at the hands of the Gestapo only by the most fortuitous and unusual circumstances.

To summarize: The conditions existing among the prisoners were not so harmonious and lofty-spirited as the radio jubilantly informed the world on the day of liberation. Bitter factional rifts, rationing-rivalry, national animosities, and sexual jealousy made life, even among the political prisoners, a war of all against all. True comradeship and fidelity existed only in very small groups. Only as liberation became more and more of a possibility and as the Americans approached, did the more contemptible attitudes moderate. Then the capable policies of the highest camp "official" and his co-workers from all nations made possible an auspicious liberation. This denouement was possible only because the S. S. had already disintegrated through the infiltration of anti-Nazi-minded elements, and because the commandant sabotaged his orders from Berlin by applying them in an unusually dilatory manner. Thus the open mutiny of April 3 and 4, 1945 by the Jewish prisoners was ignored by him, and the mutineers, comprehending the situation, were able to hide around the precincts of the camp, until the hour of liberation.

The disintegration of the S. S., which was already observable in 1943, made it possible for the political prisoners and functionaries to develop extensive secret organizations, under the cover of official ones. There was a camp police, known as "camp security," which was charged with the maintenance of order among the inmates. Besides this, there was a magnificently-equipped fire-fighting force, which had the authority to go 20 kilometers outside the limits of the camp, without S. S. supervision, if its service were required. A rescue group was formed to take all measures required to save victims during air raids, and an air wardens' organization was started at Buchenwald, as in all sections of the Reich. An excellent ambulance group was also on duty. All the units were initi-

ated by the S. S. but were entirely under the management of the prisoners themselves. At first, only German subjects could participate; but, later, all nationals were eligible, according to their percentages in the camp. All these organizations were unusually well constituted, and the credit lies with them that so many prisoners survived at Buchenwald to be liberated by the Americans.

IV

Life in Camp

A plan or outline might be helpful in giving a general idea of the organization of Camp Buchenwald. At the head was the S. S. camp commandant. Under him, was the entire S. S. troop, which supervised the management of the whole camp. The S. S. troop had its own commanding officer who was in charge of all the military services. The administration of the camp itself was under the direction of the first, second and third "camp leaders," who took their orders from the camp commandant. Directly under the commandant were the two "*Rapport*" leaders, and under them the block leaders who directly supervised the activities of the inmates. "*Rapport*" leader was the name applied to the sergeant-major of the camp who actually performed more duties than the camp leaders. Besides these staff "officials" one may note several others who were directly responsible to the camp commandant. There was a superintendent of supplies and a superintendent of labor, both commissioned officers, with two subordinates, known as labor service leaders, to carry out their orders. Each department and each labor command had an S. S. leader or "under-leader" at its head. In the S. S., commissioned and non-commissioned officers were called leader (*Führer*) and under-leader (*Unterführer*) respectively. This arrangement may appear odd, but in reality it was one of the most effective Nazi measures and was designed to put psychological pressure upon the German people and bring them under the yoke at every turn. The garrison medical officer was no subordinate of the commandant, but received his authority instead from the national medical leader himself; the doctors of the camp were responsible to the garrison medical officer. It followed, therefore, that decent S. S. doctors enjoyed extra-

ordinary opportunities to aid prisoners. It is fair to state that a majority of the S. S. doctors were faithful to the ethics of their profession. Thousands of prisoners from all countries owe their lives to medical officers who, at their own risk of punishment—even of death—favored the prisoners.

All these S. S. posts were positions of authority and control, for work of every sort was relegated to the prisoners, and control itself became diffused and lax in the later years. One result was that contacts between the S. S. and the prisoners improved and, indeed, became better the longer the war lasted. Inevitably, there were exceptions, and a prisoner still might be beaten by an S. S. man with whom he had been on good terms. Such things occurred less and less frequently, however, as the defeat of the German armies became ever more predictable. The majority of the S. S. men were cowards and had been failures in civilian life. They were only malicious, then, when they felt themselves safe. They grew steadily tamer as it became clear that the end of their reign was approaching. There were also a few who were decent by nature, but had drifted into the S. S. through some quirk of fate, and could not resign from the organization without risk of life. Sometimes one observed cruel and malicious S. S. men change completely after a happy marriage or after attaining some higher rank, while the opposite could also happen. Decent men sometimes became beasts after suffering some untoward reverse of fortune.

As more S. S. units were called to the front the veterans' places were taken by harmless troopers who did no more than their least duty and not always that. This extensive softening of the S. S. was not seized upon more promptly by the prisoners because their German functionaries lacked intellectual and political interest. Camp inmates from the western nations could not establish contacts with the S. S. because national differences, speech obstacles, and prejudices interposed barriers. Actually, a German Jew could gain the ear of an S. S. official more easily than an "Aryan" Frenchman. "Race" is a ridiculous delusion of the Nazi criminals; language and education are the really important factors in communication.

The majority of the prisoners, who were *not* nationals of the democratic countries (the difference was very easy to observe), were absorbed in problems of food, clothes, comfortable work

status, and sex. Political life in the camps had been depressed and stultified; however, had it shown signs of a powerful revival, repressions would have become stronger and more ruthless; as matters were, the intellectuals and the mentally and morally "refined" among the workmen suffered much more under the hardships of the camp than the more primitive prisoners. Having learned caution, important prisoners of ability who survived, left the administrative posts and responsibilities to mediocre men.

How did the average life of a Buchenwald prisoner appear during quiet times? In the morning, the camp was awakened so that everyone could be at his place of work at 6 a. m. During the last two years of the war the hours were the same, winter and summer, so that in winter the men had to wait over an hour at their places of work before they had light enough to begin operations. The explanation for this practice was that the camp command was able thereby to report the work hours required when asking a higher bread ration from Berlin.

On arising, every prisoner was expected to wash himself while stripped to the waist; but this was not always possible, as there were not sufficient pumps for the camp, and often there was no water. After these "ablutions," coffee and bread with a spread were given out. For the necessary morning toilet, there was an allowance of about one hour; but, in the last years of the camps, overcrowding in the blocks made each operation, however simple, a problem. After morning toilet, all prisoners had to turn out for roll call, and so to work.

There were many types of work, as in every industrial town. But unlike workers on the outside, the camp workers had no shelter from the weather, and the lowest messenger boy in an office was much better off than a skilled workman who had to labor in the open. No consideration was paid to climatic conditions. Until 1943, the Jewish prisoners were not even permitted to remain in a closed room during the noon lunch period. On one day of the severe winter of 1939-40 as many as 50 prisoners froze to death, because Commandant Koch let them work at 5° F. with insufficient clothing. These victims were largely of the so-called anti-social type, individuals picked up without plan or reason, bearing black identification insignia. During the last year of the war the pri-

oners suffered severely because of the scarcity of shoes and underclothing. Those from the warmer southlands felt the raw climate of the Thuringian woods most acutely. The noon lunch period usually lasted from 12 to 12:30. After 1942 the workday was reduced to 11 or 12 hours; before that time it had been 14 hours for "Aryans" and 16 for Jews. The rate of work was usually slow, although some of the work was terrifically hard. Particularly in some of the so-called "Jewish work units" hundreds of prisoners died of over-exertion. In such groups also the *Kapos* and work foremen bullied those under them, often more ferociously than the S. S.

When the prisoners returned to the barracks after work they faced another roll call. The duration depended upon the "*Rapport*" leader. The briefest roll call lasted 10 minutes, the longest six hours. Sick and crippled inmates had to remain standing with the healthy. Until 1942, the strictest order and quiet had to prevail on the parade ground, and the prisoners were made to stand at attention throughout the roll call. Toward the close of the war, discipline was relaxed in these details also. When the evening roll call ended, there was so-called free time which was devoted to the various urgent necessities of life: eating, bathing, shaving, getting money from the cashier (where there was always a very long wait), changing laundry, securing food extras, and other things. All these activities took much more time and energy than in civil life; they had to be attended to in overcrowded quarters filled with nervous and overstrained people. Time off for the individual was something only a few of the privileged prisoners enjoyed, but it is true that in some periods, especially in winter seasons, there was a little more "free time." Before 1942, the Jewish prisoners were compelled to work even when others rested—on Sundays, holidays and in the evenings. Often the prisoners themselves prescribed this overtime labor for the Jews, forcing them to complete work others should have done. After 1942, when Jewish workers only were employed for skilled work, this practice ceased.

The food ration was sufficient and well-balanced for the "Aryan" prisoners until December 1944. After that, there was literally no more food, and even the S. S. received short rations. Hitherto, there had always been raw fresh vegetables in season.

When, at the close of 1942, food packages were permitted to enter, many camps, including Buchenwald, had surplus food. In this particular as in others, the Jews were worse off than the rest, for few of them had any relatives left who could support them. Commandant Koch instituted a full fast day (throughout one full workday) for the Jews once each month, a custom which endured until 1942.

In the autumn of 1939 and the spring of 1942, there were periods of terrible want for the Jews, and literally hundreds died from famine. The young Russians and Poles, who were used to large quantities of food, also suffered a great deal from hunger. It was the rule that those doing light work—and that often indoors—received an abundance of food, whereas those working at hard labor out of doors were handicapped in every respect. Those well adjusted to life with strong constitutions, however, could obtain the minimum needed to maintain life—that is, until the end of 1944. Absolute famine did not set in until the winter of 1944-45. Even in the very worst times, however, there were some privileged prisoners who had an abundance.

Sanitary and hygienic standards varied in different years. Sometimes they were good and sometimes they were unbelievably bad. At the end, the chaos and the filth, the sickness, and the dangers of epidemics defied every conceivable measure, and the most energetic and efficient camp officials were powerless against the mounting problems which faced them. The hospital (*"Revier"*) was run by the prisoners, who always sought to do their best by their comrades. Originally the S. S. had decreed that no doctors should be drawn from among the prison population, but as early as 1939 the camp physician, Dr. Ding, disregarded this regulation. The hospital was well run, as well run, that is, as conditions permitted. The prisoners who worked in this department deserve honor, as other workers in peace and war are decorated for bravery or achievement. Some S. S. doctors in Buchenwald behaved correctly and very humanely toward all prisoners. S. S. Dr. Blies, from Offenbach-on-the-Main, should be honored by special mention, because of his courage in devoting his entire knowledge and skill to his medical duties, without consideration for his personal safety or welfare.

Punishments were cruel and barbaric. The least of them was standing still for hours, a penalty often increased by the order to hold the arms behind the neck. A favorate punishment was to withhold all food. Thus on November 9, 1939, after the explosion in the beer cellar in Munich, all the Jewish prisoners were penalized. Twenty-one were shot at the command of Acting Camp Commandant Hüttich. The remainder were condemned to a four-day fast and were confined for a week in total darkness. A week later the entire camp was commanded to work three full days without any food because a pig had been stolen from the reserves of the S. S., and the culprit could not be discovered—probably he was one of the S. S. men. Under Commandant Pister, however, the punishment of withholding food was abolished.

One terrible form of punishment was "tree-hanging." The victim's hands were tied together behind his back; he was lifted from the ground by a rope or chain attached to his bonds, and left hanging for half an hour to two hours. This punishment was extremely painful and often resulted in months of paralysis. The severest form of punishment, however, was flogging on the back with sticks and clubs. This might be meted out in milder or more savage degree, depending on the choice of instrument, the kind of clothing and violence of application. Severe flogging might inflict serious injuries, with weeks of crippling diseases for some victims, while the mildest form was more humiliating than painful. Official rules ordained that a doctor should be present at the scene of punishment but these were seldom observed. One bitterly-hated penalty was "work-punishment," which imposed overtime labor and so robbed the victim of what little "free time" he might hope for. There were also "penalty exercises," which were carried on as "sport" to the point of complete exhaustion. These exercises included: lying down and rising in rapid succession; jumping with knees bent; rolling the body like a log; and running a hurdle race over heaps of stones and other obstacles. These "sports" were performed for hours until complete fatigue overcame the victims. Not a few died as a result of such exertions.

The worst fate a prisoner could face was to undergo the strict inquest of the Gestapo. No human being could withstand Gestapo torture methods; if some survived without breaking it was because

by good luck they were not subjected to the full extent of the official routine. Any one who was determined to confess nothing had to commit suicide at the right moment; stories of the heroic resistance offered are not true to fact; for it is not possible for men to withstand for more than a short time the modern methods of torture that have been devised.

Until 1942, beatings and kicks in the abdomen or groin were daily camp occurrences, and the prisoners ceased to make any comment about them so commonplace had they become. A prisoner had to "take" anything without resistance, not only take it from members of the S. S., but from every man who was his superior in rank. Resistance was interpreted as mutiny and meant death. Everyone was permitted to beat a Jew, but, from 1942 on, conditions improved even in this respect, for reasons which have been suggested already.

Were there ever any pleasant items in the life of Buchenwald? Yes, for those who were not utterly exhausted by their toil. There were excellently-organized libraries, rich in scientific and literary works, open to every prisoner. Movies, concerts, and sometimes theatrical and cabaret performances existed in the happier periods of the camp history. Thus Fritz Gruenbaum and Paul Morgan, and many other artists or amateurs, entertained during the quieter seasons at Buchenwald. A concert orchestra under a director from the Conservatory at Prague was organized and developed a remarkable artistic standard.

Did the prisoners have leisure for such amusements? This was a matter which varied from season to season, and year to year. There were times when Sundays were entirely free, but such periods did not last long. More often, work ceased at 1 p. m. on Sundays (although sometimes it lasted the whole day). After the roll call at 3 p. m. the prisoners were free. Prisoner-artists who provided entertainment could obtain free time at almost any hour, and there was a special artists' unit: orchestra, sculpture and painting.

After the arrival of Commandant Pister there were movies every night, and there was "free time" every night after 7:30, providing the roll call had proved correct. Consequently, it was ordinarily possible to attend a performance, which was more usually done in winter. Were not the prisoners too exhausted? As I have said

previously, the work was not in general too arduous, with the exception of that of special work battalions. It was common for thousands of prisoners to evade the heaviest tasks, and, therefore, there was always an audience. But the lowest strata of prisoners (and these included the majority) were left out of the "comforts" of the camp.

Even in these more pleasurable interludes of camp life a sharp disharmonic note intruded and should not be concealed. The theater and movie hall were the same buildings in which, mornings and afternoons, corporal punishment was administered. They were also the stations at which the parades assembled when groups were dispatched to the gas chambers or other centers of extermination. A prisoner might, therefore, have endured a flogging in the morning, have been mustered out for a life-or-death roll call in the afternoon, and see a movie or hear a concert in the same hall that same evening. That was Buchenwald.

Organized sport was permitted, but it was indulged in almost exclusively by those prisoners who worked in the bureaus and offices all day.

In the summer of 1943, a brothel was set up, in which 15 girls, most of whom were professional prostitutes, were employed. As already recorded, this intensified the hypocrisies and jealousies which were prevalent and did nothing to reduce the homosexuality to any appreciable extent. Jews were prohibited from entering the brothel; and, if this order had not been strictly observed, many of them would have been murdered.

This article is intended as an objective description of Buchenwald, and every word set down is true to the facts.

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A STUDY OF THE RESULTS OF TREATMENT AND PAROLE ADJUSTMENTS OF 712 NEUROSYPHILITIC PATIENTS ADMITTED TO KALAMAZOO STATE HOSPITAL FROM 1926 TO 1939*

BY ESTELLA M. HUGHES, M. A.†

The object of this study was to evaluate the results of different forms of treatment for neurosyphilis given in the Kalamazoo (Michigan) State Hospital. The period chosen coincides with the introduction of malaria as a therapeutic agent; it was first used at Kalamazoo in January 1926. The terminal date of 1939 was selected to provide a parole experience for those treated late during the period.

In the 14-year period covered by the study, there were 712 admissions of patients whose subsequent diagnosis was neurosyphilis. There was considerable fluctuation in the annual number of admissions, with, however, a general downward trend for the period as a whole, which is in keeping with national statistics as reported in the Population-Special Reports of the United States Census.[1] Reference to Figure 1 indicates that a peak for admissions was reached in 1928 with 72 cases, the figures falling to a low of 33 in 1935 and rising slightly thereafter. Admissions for females were relatively constant; their smaller numbers are less likely to mirror the larger trend. The decrease in the yearly number of admissions may reflect an actual regional decrease in the incidence of the disease as has been noted, or it may be more apparent than real—the result of greater use of treatment centers, or practitioners' services elsewhere.

*The nature of this study and its scope were suggested by Dr. R. A. Morter, medical superintendent of the Kalamazoo (Michigan) State Hospital, and the proposed outline of inquiry was approved by him. The basis of the study is this hospital's clinical records. Field follow-ups on the paroled cases were made by Regene Diamond, Katherine Ascherl and Alice Brauch, who were then members of the social service department. Assistance in tabulations was given by three other members of the department, Mabel Sewall, Duaine Holm and Elsinore Tressman. Helpful criticism and directions from Dr. Edwin Lemert are acknowledged.

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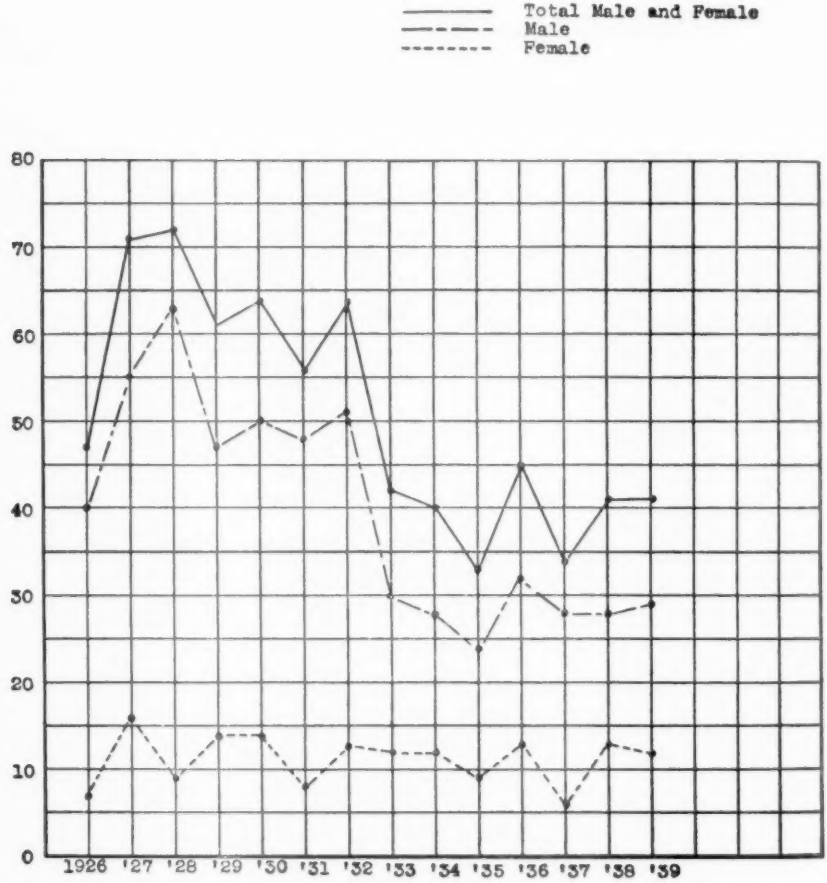
Figure 1

A Study of the Results of Treatment and Parole Adjustments of 712 Neurosyphilitic Patients Admitted to Kalamazoo State Hospital from 1926 to 1939



An analysis of the total case population discloses a ratio of 3.45 males to each female. The mean age of all patients was 44.3 years, with the females having a lower mean age, 41.1 years. Table 1 shows the number and percentage distribution of the cases by 10-year class intervals. As might be expected, few cases occurred under 20 years of age, and the age bracket of highest incidence was "50 years of age and over." Other data indicated that admissions of negroes amounted to slightly more than 5 per cent of the total, a figure about two and one-half to three times the proportion this

race makes up of the regional population. The actual numbers were too small to justify their tabulation as a separate group.

Table 1. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Age

Age group	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Under 20	4	.7	2	1.3	6	.8
20-29	22	4.0	13	8.1	35	4.9
30-39	131	23.7	42	26.2	173	24.3
40-49	191	34.6	51	31.9	242	34.0
50 and over	204	37.0	52	32.5	256	36.0
Total	552	100.0	160	100.0	712	100.0

Table 2 reveals a very high occurrence of cases from urban areas, 80.8 per cent of the total, corresponding to the generally urban nature of syphilitic infection. It is of some interest from the public health point of view to note in this table that propor-

Table 2. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Rural-Urban Origins

Origin	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Urban	451	81.7	124	77.5	575	80.8
Rural	94	17.0	34	21.2	128	17.9
Unknown	7	1.3	2	1.3	9	1.3
Total	552	100.0	160	100.0	712	100.0

tionately more females than males come from rural areas, a difference, which if translated into rates, would have been much greater, since the sex ratio is higher in rural areas than urban areas. Possibly this is caused by higher marriage rates of rural females, since a large amount of infection of females is from their marital partners.

Tables 3 and 4 show the education level and occupational status of the 712 patients. Following the normal expectation in a state hospital, in contrast to a private mental hospital, the patients were drawn from the less educated social strata, and from unskilled and

Table 3. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Educational Level

Education	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
None	9	1.7	2	1.3	11	1.5
Literate	213	38.6	68	42.5	281	39.5
Grade	284	51.2	82	51.2	366	51.5
College	15	2.8	1	.6	16	2.2
Unknown	31	5.7	7	4.4	38	5.3
Total	552	100.0	160	100.0	712	100.0

semi-skilled occupational classes. An exception is seen in the case of male occupations, where 25.2 per cent of the males were skilled workers. This is explained by the large number of admissions from Grand Rapids in Kent County (which incidentally has one of the highest county rates of first admissions in the state), where large numbers of workers are employed as furniture craftsmen.

Table 4. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Occupational Level

Occupational classification	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
None	20	3.6	48	30.0	68	9.6
Professional and kindred workers	11	2.0	0	00.0	11	1.5
Salespersons	37	6.7	5	3.1	42	5.9
Clerical workers	26	4.7	12	7.5	38	5.3
Service workers	49	8.9	74	46.2	123	17.3
Craftsmen (skilled)	139	25.2	2	1.3	141	19.8
Production workers (semi-skilled)	94	17.0	2	1.3	96	13.5
Physical labor workers (unskilled)	147	26.6	10	6.2	157	22.1
Unassigned persons	29	5.3	7	4.4	36	5.0
Total	552	100.0	160	100.0	712	100.0

The cases admitted during the years of the study showed limited differentiation so far as symptoms were concerned, with the bulk of the diagnoses general paresis. Reference to Table 5 discloses

87.5 per cent falling in this category in contrast to 12.5 per cent in that of cerebral syphilis. Sex, as can be seen, seemed to have no bearing whatsoever on predisposition for the disease to assume one or the other form.

Table 5. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Diagnosis

Diagnosis	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
General paresis	485	87.8	138	86.2	623	87.5
Cerebrospinal syphilis	67	12.2	22	13.8	89	12.5
Total	552	100.0	160	100.0	712	100.0

Three types of treatment were administered to patients: malarial therapy, chemotherapy, and a combination of these. It was assumed that, whenever possible, the combined treatment should be given in preference to either therapy alone. Patients were inoculated with 5 cc. of blood from another patient previously inoculated with the benign tertian strain of malaria. High fevers were permitted, and the maximum number of paroxysms was limited to 12. The supplementary chemotherapy consisted—ideally—of 30 to 40 arsenical and 60 to 80 bismuth injections. Variations in the chemotherapy specifics and their ratios occurred in relation to the patient's age and physical tolerance, and to some extent in relation to the preferences of the staff physician.

Table 6 shows the number and percentage of completely and incompletely-treated cases receiving the various treatments, plus those who received no treatment. This last group was statistically large enough to constitute at least a partial scientific control. The standard combined treatment was carried through in 29 per cent of the total cases. Malaria alone was carried through in 3.2 per cent. Chemotherapy alone was used in only 20 per cent. Treatment was interrupted and remained incomplete in 36.1 per cent of the total cases. A relatively small number of cases (11 per cent of the total) received no therapy, and in this group, a relatively larger number of females than males received no treatment. In explanation of this untreated percentage, it should be stated that

some patients died or were removed before treatment could be instituted and that the physical condition of others was considered too hazardous for the undertaking.

Table 6. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Type of Treatment

Treatment	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
None	51	9.2	27	16.9	78	11.0
Malaria (complete)	12	2.2	11	6.9	23	3.2
Malaria (incomplete)	30	5.4	2	1.2	32	4.5
Chemotherapy (complete)	120	21.7	26	16.2	146	20.5
Chemotherapy (incomplete)	82	14.9	19	11.9	101	14.2
Combined (complete)	163	29.6	45	28.1	208	29.2
Combined (incomplete)	94	17.0	30	18.8	124	17.4
Total	552	100.0	160	100.0	712	100.0

The final outcome of the total of 712 cases is shown in Table 7. From this, it will be seen that deaths within the hospital amounted to 43.4 per cent of the total, with remissions or their equivalent obtained in 35.0 per cent, the remainder—21.6 per cent—left in the hospital in various stages of deterioration. These figures indicate a greater percentage of remissions than reported by Beck-

Table 7. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Sex, According to Final Disposition

Disposition	Male		Female		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Died	245	44.4	64	40.0	309	43.4
Remained in hospital	111	20.1	43	26.9	154	21.6
Paroled	196	35.5	53	33.1	249	35.0
Total	552	100.0	160	100.0	712	100.0

man[2] in his review of 4,012 cases showing 20.0 to 30.0 per cent, but less than the percentage recorded by Hand and Wile[3] (53.1 per cent) and also less than that of Bellinsin,[4] who gives 35.0 to 55.0 per cent, depending upon the type of therapy. The remissions shown in this study run 10.0 per cent under those of Moore's[5] un-

selected clinical material, which included all types of paresis, early and advanced. However, it should be recognized that strict comparisons of such data cannot be made, due to a lack of standardized definitions of a "remission," and variations in criteria for discharge and parole.

According to Table 7, sex played an immaterial role in determining outcome of cases. A slightly higher percentage of men than women died, but this was balanced by the slightly greater percentage of males paroled.

Table 8. Number and Percentage Distribution of 712 Kalamazoo State Hospital Neurosyphilitic Patients by Age, According to Final Disposition*

Disposition	Under 40		40 and over		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Died	57	26.5	252	50.6	309	43.4
Remained in hospital	52	24.5	102	20.4	154	21.6
Paroled	105	49.0	144	29.0	249	35.0
Total	214	100.0	498	100.0	712	100.0

*Includes both males and females.

Age, contrary to the findings of Hand and Wile,[6] and Solomon and Epstein,[7] did seem to have a significant bearing upon the outcome of the cases, particularly of the males. Table 8 shows that the percentage of deaths was nearly twice as high for patients 40 years and over, as for patients under this age. Paroles ran 49.0 per cent for patients under 40 years of age, and only 29.0 per cent in the older age group. Tables 9 and 10, based upon cases with completed treatment, seem to point to an interactional influence

Table 9. Number and Percentage Distribution of 295 Kalamazoo State Hospitald Male Neurosyphilitic Patients in Whom Treatment Was Completed, by Age and Final Disposition

Disposition	Under 40		40 and over		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Died	14	12.9	74	39.8	88	29.8
Remained in hospital	24	22.9	46	24.7	70	23.7
Paroled	71	64.2	66	35.5	137	46.5
Total	109	100.0	186	100.0	295	100.0

between age and sex, so far as final outcome of cases was concerned. In terms of percentages, three times as many males 40 years of age and over died as those in the lower age category; conversely, the parole percentage for the younger men was almost twice what it was for the older men. Females displayed only a slightly more favorable outcome in the younger age group than in the older, but this may have been due to a greater number of untreated cases in the younger group.

Table 10. Number and Percentage Distribution of 82 Kalamazoo State Hospital Female Neurosyphilitic Patients in Whom Treatment Was Completed, by Age and Final Disposition

Disposition	Under 40		40 and over		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Died	13	34.2	17	38.6	30	36.6
Remained in hospital	10	26.3	10	22.8	20	24.4
Paroled	15	39.5	17	38.6	32	39.0
Total	38	100.0	44	100.0	82	100.0

An apparent evaluation of the efficacy of the three types of treatment employed can be drawn from Tables 11 and 12, where the final dispositions of completely treated cases in each category can be compared with each other, and with a control group in which no treatment was administered. Since age was found to influence results, the data were tabulated for two age groups, "under 40

Table 11. Number and Percentage Distribution of 155 Neurosyphilitic Admissions to Kalamazoo State Hospital (1926-1939), Under Age 40 by Type of Treatment Completed, According to Final Dispositon*

Final disposition	Type of treatment								Total	
	None		Malaria		Chemotherapy		Combined			
	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percent age
Died	4	50.0	2	20.0	18	41.8	7	7.4	31	20.0
Remained in hospital	2	25.0	1	10.0	5	11.8	28	30.0	36	23.2
Paroled	2	25.0	7	70.0	20	46.4	59	62.6	88	56.8
Total	8	100.0	10	100.0	43	100.0	94	100.0	155	100.0

*Includes both males and females.

Table 12. Number and Percentage Distribution of 300 Neurosyphilitic Admissions to Kalamazoo State Hospital (1926-1939), Age 40 and Over by Type of Treatment Completed, According to Final Disposition*

	Type of treatment									
	None		Malaria		Chemotherapy		Combined		Total	
Final disposition	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage
Died	56	80.1	5	38.4	58	56.3	28	24.5	147	49.1
Remained in hospital	5	7.1	0	0.0	22	21.3	34	29.9	61	20.3
Paroled	9	12.8	8	61.6	23	22.4	52	45.6	92	30.6
Total	70	100.0	13	100.0	103	100.0	114	100.0	300	100.0

*Includes both males and females.

years of age'' and ''40 years of age and over.'' The untreated control group of those ''under 40 years of age'' was too small a sample to support any conclusions, but the sample for the older group was more than sufficient for this purpose. In the latter, remissions permitting parole amounted to 12.8 per cent. This percentage increased to 14.1 when the two samples were added together. This surpasses the 5.0 per cent automatic remission rate for paresis mentioned by Moore.[5] For patients ''under 40 years of age,'' malarial treatment appeared to be unusually successful; eventually 70.0 per cent of the patients so treated were paroled. Combined therapy ranked second in leading to paroles, with chemotherapy least productive of discharge. While the malarial sample was small in this ''under 40'' group (10 cases), the same rank order of the therapies held for the older group with respect to parole, a fact which tends to counterbalance the smallness of the samples.

Combined treatment was the therapy seemingly the least hazardous to the life of the patient, while chemotherapy alone was associated with the highest percentage of deaths of all ages. A tenable hypothesis that this treatment was in many cases lethal could perhaps be offset by the possibility that those receiving only chemotherapy may, on the whole, have presented a poorer group of risks than the others. Malaria seemed to have a bimodal reaction, with patients so treated inclined either to improve sufficiently for pa-

role, or dying in the hospital. This tendency is noticeable also in the chemically-treated group "under 40 years of age."

Certain difficulties are immediately confronted in making evaluations of treatment success, as demonstrated by parole adjustments. The well-known ironic medical fact that "treatment may be a success but the patient remain unchanged" enters to distort the findings. Therapy may completely eradicate the spirochete from the body of the patient; but, if scarring and generalized tissue breakdown has occurred, then little change will be apparent objectively, although in the light of psychosomatic theories this idea can probably bear re-examination. However, assuming that this idea is sound, then it is clear that the absence of homogeneity in the cases at the beginning of treatment compromises conclusions as to the value of treatment.

Observation by members of the hospital's social service department indicates that, by and large, those patients treated for neurosyphilis who leave the hospital on parole are good risks in comparison with other kinds of mental patients. They adjust with less social friction than do patients with functional diagnoses. Their relatives and friends seem better able to grasp the meaning of behavior that is altered through a demonstrable organic disease than they can understand the unpredictable behavior of the non-organic case. Familial and communal attitudes are more understanding and more continuously tolerant, thus producing a better cushioning of the environment. These informal impressions, at least in part, are substantiated by parole adjustment records.

Tables 13 and 14 show the adjustments of the treated paroled cases according to Rennie's[8] classification of social adjustment. For patients under 40 years, 65.8 per cent were classified as recovered to their previous level, 14.5 per cent were productive in varying degrees, and 18.4 per cent were family invalids. For those "40 years of age and over," 37.2 per cent were designated recovered, 21.8 per cent productive, and 34.6 per cent invalided. This method of classifying parole adjustments does not shed too much additional light upon the preferred method of treatment other than perhaps to underscore the "roughness" of chemotherapy. In both age groups, this treatment was associated with the greatest percentage of unproductive family invalids. Although

Table 13. Number and Percentage Distribution of 76 Completely Treated Kalamazoo State Hospital Neurosyphilitic Paroled Patients Under 40 Years of Age, According to Social Adjustment

Social adjustment	Malaria		Chemotherapy		Combined treatment		Total	
	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage
Recovered to previous level	2	33.3	4	21.0	20	40.0	26	34.2
Recovery at a reduced level	2	33.3	5	26.3	17	34.0	24	31.6
Productive with symptoms	0	0.0	1	5.3	2	4.0	3	4 0
Partially productive with relapses	0	0.0	0	0.0	0	0.0	0	0.0
Productive family invalid	2	16.7	3	15.8	3	6.0	8	10.5
Family invalid	1	16.7	6	31.6	7	14.0	14	18.4
Adjustment not learned	0	0.0	0	0.0	1	2.0	1	1.3
Total	7	100.0	19	100.0	50	100.0	76	100.0
Paroles not located	0		1		9		10	
Total cases	7		20		59		86	

combined treatment cases were relatively most numerous in the two "recovered" categories, they were also relatively more numerous than malaria-only cases in the complete invalid category for patients of "40 years and over," and they approached the percentage of malarial invalids "under 40 years of age." If the premise is correct that patients receiving combined treatment were the most favorable risks, or perhaps the least advanced cases, the question is raised as to the worth of supplementing malarial treatment with chemotherapy. The further question as to whether deaths may have ensued unnecessarily from the chemicals must also be faced. The control group of untreated patients on parole was too limited to make generalization possible.

Tables 15 and 16 summarize parole adjustments from a somewhat different approach. While the data on "social adjustment" were related to the pre-disease level of the patients, the more restricted data on occupation are related to admission levels. In some respects this is a better measure of treatment results than

Table 14. Number and Percentage Distribution of 78 Completely Treated Kalamazoo State Hospital Neurosyphilitic Paroled Patients 40 Years of Age and Over, According to Social Adjustment

Social adjustment	Malaria		Chemotherapy		Combined treatment		Total	
	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage
Recovered to previous level	2	33.3	4	21.0	20	40.0	26	34.2
Recovery at a reduced level	1	12.5	5	23.8	10	20.4	16	20.5
Productive with symptoms	0	0.0	1	4.8	2	4.1	3	3.9
Partially productive with relapses	3	37.5	0	0.0	6	12.2	9	11.5
Productive family invalid	0	0.0	1	4.8	4	8.2	5	6.4
Family invalid	2	25.0	10	47.8	15	30.6	27	34.6
Adjustment not learned	0	0.0	2	9.5	3	6.1	5	6.4
Total	8	100.0	21	100.0	49	100.0	78	100.0
Paroles not located	0		2		3		5	
Total cases	8		23		52		83	

the stricter measure in the previous tables. However, the separate tabulations for malaria in these two tables are not very significant, because of the small size of the sample. Beyond this, the tables again bear out the consistent association of chemotherapy when given alone, with unfavorable outcome—in this instance, deterioration below admission level. When the data from both tables are added together and cases where results are "unknown" are eliminated in the computation, malarial therapy and combined therapy have about the same degree of success; admission-level and above-admission-level cases are 73.3 per cent of the malarially-treated and 74.6 per cent of the combination-treatment patients. In contrast, only 56.5 per cent of those chemically treated fell into the two high categories.

The conclusions from this study, at best, must be tenuous and generally suggestive, rather than positive. Research of this order and upon this particular problem is handicapped by lack of any fairly accurate measure of the progress of the disease at the time

Table 15. A Comparison of Pre-Admission and Post-Parole Occupational Levels: Number and Percentage Distribution of 76 Completely Treated Kalamazoo State Hospital Neurosyphilitic Paroled Patients Under 40 Years of Age

Occupational level	Malaria		Chemotherapy		Combined treatment		Total	
	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage
Above admission level	2	28.6	5	25.0	15	25.4	22	25.6
Same as admission level	5	71.4	5	25.0	23	39.0	33	38.4
Below admission level	0	0.0	9	45.0	12	20.3	21	24.4
Unknown	0	0.0	1	5.0	9	15.3	10	11.6
Total	7	100.0	20	100.0	59	100.0	86	100.0

when treatment is begun, so that a group which is homogeneous from the standpoint of symptomatology, as well as race, sex and age, could be studied in relation to relative effectiveness of different therapies. Several autopsies studied and reported by Scholten[8] of the Kalamazoo State Hospital indicate that advanced cases of neurosyphilis yield to no form of treatment. Age, at best, is only an indirect index of the probable seriousness of the infection, while serological tests and clinical symptoms do not always correlate. Recent developments in psychosomatic medicine consider the patient's psychological reaction to his or her disease and the hos-

Table 16. A Comparison of Pre-Admission and Post-Parole Occupational Levels: Number and Percentage Distribution of 78 Completely Treated Kalamazoo State Hospital Neurosyphilitic Paroled Patients 40 Years of Age and Oover

Occupational level	Malaria		Chemotherapy		Combined treatment		Total	
	No.	Percentage	No.	Percentage	No.	Percentage	No.	Percentage
Above admission level	1	12.5	0	0.0	11	21.1	12	14.5
Same as admission level	3	37.5	13	56.5	25	48.1	41	49.4
Below admission level	4	50.0	8	34.8	13	25.0	25	30.1
Unknown	0	0.0	2	8.7	3	5.8	5	6.0
Total	8	100.0	23	100.0	52	100.0	83	100.0

pital experience itself of significance. It is interesting to note that some patients made better social adjustments after parole than they had ever made in their lives. It has been postulated that a poorly-adjusted person may be better fitted to cope with his environment after infection with neurosyphilis and treatment —largely through being able to focus his conflicts or anxieties upon organic symptoms, and thus rationalize past failures—particularly with the greater communal tolerance that goes with them. It has been argued that neurosyphilis, or the conscious reaction to it and to hospitalization, can precipitate a latent psychosis, or that a case which begins as predominantly organic can end as functional. Several writers support this.

The other procedure that could be followed profitably would necessitate a purely random sample, so that it could be assumed that the different types of cases would be present in equal proportions for each group. Such a method would demand a very large sample, much larger than the one used in this study, and one drawn from a wide geographical area. Such a sample would be difficult to obtain at the present time because of the absence of standardized procedures and terminology from one hospital or treatment center to another. It must be admitted that the sample studied here was neither random nor controlled, nor could it be under the circumstances. There was a tendency to treat proportionally fewer women than men, and a pronounced inclination to segregate cases for various forms of treatment upon the bases of physical condition, with (presumably) the best risks receiving combined therapy, the second best risks receiving malaria alone, and the poorest risks having chemotherapy only.

The tentative conclusions of this study are as follows: (1) Malaria, even without follow-up by chemotherapy, seemed to be an effective treatment. (2) Dependence upon chemotherapy, which in the absence of malarial treatment has been the accepted procedure, raised the expectation that cases so treated here would give more satisfactory results than actually were obtained. (3) In this study, at least, the supplementing of malarial treatment with chemotherapy did not seem to increase the chances for eventual parole or satisfactory parole-adjustments. (4) There is some evidence pointing to the conclusion that combined therapy may be

more hazardous than malaria used alone. (5) Age appeared to affect the outcome of treatment. (6) The outcome of cases can be explained partially in terms of physical conditions as well as in terms of treatment.

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M. D. (MASTER OF DICE)

BY JAMES A. BRUSSEL, M. D., F. A. C. P. (Asso.)

Psychiatrists frequently find, in their contact with psychopathic personalities, certain individuals who achieve economic, historical and even cultural success although psychopaths generally shun effort sedulously. This select minority sometimes acquires fame through sheer luck. It has been postulated that those psychopaths who do display energy do so either in tribute to their overwhelming narcissism or because they have ulterior motives driving them on. Soldiers of fortune, stock gamblers who make story-book "killings" in Wall Street, Don Juans and Beau Brummels, tramps who turn to earthy music and literature, ne'er-do-well drifters who become theatrical headliners because of a casting "break" . . . all are examples of a combination of good fortune and a certain degree of energy. Rare indeed, in the annals of psychiatry, is a physician who could be diagnosed as possessing a psychopathic personality. Such a man, however, was Jerome Cardan, known to posterity as a skillful manipulator of gaming dice!

Proficiency at dice, however, as we shall see, was not this remarkable man's only gift, for his prodigious mind, rich in its inborn endowment, ran the gamut from mind-reading and algebra to literature and diagnosis. Thanks to his own ever-moving quill pen and the research of his biographer, Henry Morley, our knowledge of Dr. Cardan is based on published and well-established fact. Otherwise this biography would read like a whimsical movie cartoon and tax the credulity of the most gullible.

Christened Girolamo Cardano, Latinized as Hieronymus Cardanus, and Anglicized as Jerome Cardan, our subject has been aptly referred to as "the wisest fool and most foolish wise man." With unmitigated narcissism, he was convinced he would be a shining light in the annals of science and became his own most profuse and flattering biographer. Proof of this is furnished by his published works, numbering 131, and the 111 unpublished manuscripts he left. Cardan was the most successful scientific author of his day, and his works have probably enjoyed more reprintings than any others; but, paradoxically, his most popular writings were the

most foolish. In 1663 Charles Spon of Paris published them in 10 folio volumes!

Cardan came into this world, *circa* 1501. His mother, a youthful and comely widow, failed to complete her marriage rites, and the stigma of bastard plagued Cardan all his life. As a child he was so frail and weak that it was predicted that he would die young; but he survived his seventy-fifth birthday. From his earliest days, Cardan had an innate love for mathematics and an insatiable thirst for dice. His knack of throwing the ivory cubes must have been congenital, for the most adept contemporary gamblers gasped in amazement and paid heavily to discover that their handling of the dice was but amateurish fumbling by comparison.

Morley emphasizes Cardan's childhood physical deficiencies: ". . . it is more than commonly essential that we know a little of the body that he carried to his work, for its unsoundness influenced his conduct and caused many a wise man to shrug his shoulders, both among contemporaries and long afterwards, and even to this day, over the question, 'Had he not madness in his composition?' " Many psychiatrists might be inclined to diagnose Cardan as a paranoid schizophrenic, but the extreme extraversion, the constant aggressiveness in which the doctor-gambler battled toe to toe with reality-factors, the lack of regressive features over three-quarters of a century, seem to preclude this diagnosis. If there were madness, then the psychosis was cultured on a medium of a psychopathic personality, the derangement becoming simply an accentuation of Cardan's primary, personality-reaction type. On the other hand, psychoneurosis is not easily eliminated. Morley insisted Cardan was a neurotic, symptoms of which Cardan himself recorded in his writings, with dreams and unusual ideas which read like a case record from the files of Sigmund Freud. Certainly Cardan is a glorious and humor-provoking individual for psychiatrists to study. There is no doubt that he was *not* overtly psychotic. Cardan never retreated from reality. If anything, he threw himself into the world of society with rare vigor and vitality!

In 1520 he left home and set out for Pavia, one of the great centers of learning at that time, and the seat of the oldest medical college in Italy, dating its origin back to Charlemagne. Cardan was an outstanding student in mathematics and followed this with a

course in medicine. Upon completion of his studies, he traveled to that other cultural center, Padua, where he unwisely accepted the post of rector of the gymnasium. The rector was the titular head of the university whose functions included settling arguments among students, supervising the faculty, and holding court in general. Actually, the undesirable work was done by the pre-rector, while the rector was supposed to be a man of means who opened his purse on the slightest provocation. Generally the post was avoided with studied vigor as an honor that was not worth the price or prestige. Morley says it is impossible to believe that this position was accepted by this "clever, penniless, disreputable young scholar of twenty-four." It seems that the youthful rector had none of the honors or rights that went with the appointment, nor is there any record that he took up his duties with the attire and accessories which such an honorable assignment demanded. Nevertheless, he filled the rectorship for a year, giving banquets and lavish social functions with money which must have come from his hard-working mother in Milan. But we must not forget that money was never an obstacle to a man like Jerome Cardan who, given a pair of dice, could readily win a few thousand *lire*.

As for his degree, let Morley tell the story: "He was rejected twice; but when he made his third effort, the adverse voices were reduced to nine, and he was admitted Doctor of Medicine, and, received with due solemnity the open and shut book, the barette, the ring, and the kiss. The open book signified things known to him that he was authorized to teach; the closed book signified the knowledge that it yet remained for him, and was his business, to acquire. The barette was of an ecclesiastical form, and signified that he was consecrated as a priest to science, and by its name (bi-rect), twice right, some thought it also signified that teachers ought to be correct in practice as in theory. By the ring he was espoused to his profession. The kiss was the symbol of the brotherhood to which he was admitted, and the peace and harmony that should prevail among all fellow-laborers in art or science. Then in the cathedral he was ushered to a seat by the prior, further symbolizing that, as a man of learning, he was qualified to sit among the princes of the earth. So Jerome was made a doctor

in the famous University of Padua. He was then twenty-five years old."

He hung out his shingle in a small town, Sacco, about 10 miles from Padua. He did not go back to Milan because he was afraid of the famine, pestilence, plague and war that had beseiged that cathedral city. His distorted mind rested on a distorted body. His arms were thin, his left hand well-molded with slim, tapering fingers, although his right hand was clumsy and deformed. Undoubtedly Cardan was a confirmed sinistral thrower at the gaming table. His hair was sparse, giving him a high, intellectual brow; and, with years, he affected a skullcap on a shaven cranium. He had a straw-colored beard that was forked at the ends. His clumsy gait may have been due to organic pathology or merely to his manner of walking, but he was forever varying his pace, first fast, then slow, then fast again, shuffling along with his head down. Morley says that in his speech, "he [Cardan] was too copious and too deficient in amenity." His favorite sport was fishing. "He had a taste for cats and dogs and little birds, so that he even names them with history, music, and other things that adorn this transitory scene, placing them in his list between liberty and temperance on the one side, and on the other side the consolation of death, and the equal ebb of time over the happy and the wretched. Among his follies he numbers an inability to part with living things that have been established once under his roof. 'I retain,' he says, 'domesties that are not only useless to me, but that I am told are a scandal to my house; I keep even animals which I have once accepted, goats, lambs, hares, rabbits, storks, so that they pollute me the whole house.' " Is this the anal-erotic hoarding of the regressing schizophrenic, or is it the deliberately-assumed oddity of conduct of the publicity-seeking psychopath who knows no limits in the wild hunt for recognition as "someone different"? What of Bernhardt, who retired each night to her fur-lined coffin? What of the lecherous Liszt, pious in his ridiculous priestly garb, of whose four-score or more children few knew who their parents were?

On the other hand, consider Cardan's marriage when he was 30. He had had a dream in which he beheld a lovely lass attired in white while he was walking along a street in heaven. In his dream he passed an open gate at which stood this beautiful woman and

he approached her, embraced and kissed her; but a gardener came along and shut the gate between them, so that Cardan was left hanging to the lady's neck. This dream seems not difficult of interpretation! However, his neighbor's house caught fire, and in the flames, the physician espied the daughter, dressed in white, at the window. In one way, the dream materialized: The gate to paradise did close, parting the couple; for after his first years of deprivation and hard work, just as riches came to him, his wife died.

In 1532, Cardan had moved to Milan and set up practice, but his colleagues refused to recognize a man of illegitimate origin. Thereupon, Cardan moved to the village of Gallarate where the citizenry, for some unaccountable reason, rejected his services or were unusually healthy. Lack of success embittered Cardan and he began to have morbid thoughts, attaching secret omens to every sensation. In 1534, there is evidence that his psychopathy may have turned into a genuine mental disease. Destitute and shunned, he closed his office, and with his wife and child came back to Milan and applied for institutionalization at a place that cared for the sick and needy, of which Cardan was certainly both. We may well ask: Was he actually mentally ill or was this the consummate acting of a down-and-out psychopath who found sustenance and lodgings?

As soon as he was offered, with a living wage, the post of lecturer on geometry, arithmetic, and astronomy, Jerome Cardan made a remarkable and swift recovery! This position had been obtained for him by his old friend, Fillipo Archinto. It may be doubted also that he obeyed the edict of the College of Physicians forbidding him to practise medicine.

For the next five years the man suffered greatly, what with his physical infirmities, unpaid bills, professional enemies, and the squalor of poverty. He tried to comfort himself with dice, endless writing, and music, in the order named. Now he began to study eminent authorities in philosophy, mathematics and literature. His passion for dice, he apologized for, by declaring: "Philosophers may play, but wise men are as kings enjoying the higher pleasures." His mathematical studies practically put an end to what medical practice he had enjoyed. Even Morley says: "A physician even in our own day cannot acquire reputation in any branch of

literature or science that does not bear directly upon tongues and pulses, without forfeiting a portion of the practice that he might have gained with ease if he had been a duller man, or if he had but hidden some part of his light under a bushel."

Up to 1536, Cardan had never seen anything he had penned in print, but a friend, Ottaviano Scoto, senior, then published, strange to relate, his *Bad Method of Practice Among Physicians.* In the dedication, the pot who called the kettle black averred: "The things which give most authority to a physician in these times are habits, attendants, carriages, character of clothes, cunning, suppleness, a sort of artificial nambypamby way; nothing seems to depend on learning or experience." It would be well if this criticism had quite ceased to be applicable. It did not lose its force for at least two hundred and fifty years, and is in our own day only beginning to grow obsolete. Here, then, was the psychopath's love for Thespianism, sham, and masking-veneer, bordering on charlatanry. Morley stamps this a clever book in which Cardan denounces 72 mistakes in practice, one of which must appeal to many today . . . the granting of wine to the sick. Cardan actually preceded wiser and better men such as Locke who said, "It is better to do nothing than to do amiss," and Osler with his "watchful neglect," when the sixteenth century writer stated, "It is better to do nothing with physic than too much with it."

He gradually acquired an enviable reputation as a skilled mathematician, particularly in algebra, but as his fame spread, his enemies increased. They were jealous of him; and, he, with his basic personality defect, was suspicious of them. But he must have had some friends, for eventually he was admitted to the Milan College of Physicians. Now he really began to write in earnest, and his publications appeared, one on the heels of another. The demand for them was remarkable, and he must have enjoyed tremendous sales. Some of his literary efforts were amazingly scholarly and antedated later-recognized scientific achievement by a great many years. For example, he devised a method of punched-out printing for the blind, not unlike Braille, and sign-teaching for the deaf in his *De Subtilate Rerum,* three centuries before modern instruction for the sightless and deaf had been discovered!

Even though the next few years were passed in study and lucrative publishing, Cardan's gaming got the upper hand. He sought out the company of gamblers and shunned his professional confreres, so that he rapidly became poorer than ever. His psychopathic personality could not be denied, even under the most favorable circumstances! He would turn to his dice rather than take up a legitimate position with good pay. In 1544, however, he yielded, and moved to Pavia to assume a mathematics instructorship paying 250 gold crowns a year.

In 1543 Cardan had come across some horoscopic writings, including astronomy and astrology, composed by Joannes Petreius of Nuremburg. These definitely appealed to his innate exhibitionistic streak. He had started a biography of Galen but had never completed it. It seems he wrote "both for fame and for the fire," because he destroyed much of his composition, saying it had been an outlet for some inner foolishness. Cardan was no impetuous, dash-it-off author; he polished, re-edited, and amended everything he wrote, whether it was destined for the hearth or press. On this he said, "They who write without digestion are like men who eat crude things; for a slight and temporary satisfaction they inflict upon themselves a grave and lasting harm." Cardan now "went all-out" for the quackery of astronomy, astrology, ghosts, spirits, omens and dreams. Perhaps this pseudo-scientific approach carried more weight than medicine in those days, for the Pope asked him to be his personal physician, and the same invitation came from Denmark's Christian III! Suddenly success descended on Cardan, both as a teacher and a practitioner. His salary was advanced to 400 gold crowns, and for the first time hunger and want were unknown to his household.

He was called as a consultant to the bedside of Archbishop Hamilton in Scotland. En route, he stopped off at Paris to pick up Cassanate, that prelate's doctor, who traveled to Edinburgh with the Italian physician. In the French capital, Cardan dined with Fernel and de la Böe. The latter was one of the most eminent anatomists of the time. Ever the opportunist, Cardan held open clinic for all the notables of the country who flocked to the wily doctor for medical advice. From the archbishop, he received 1,800 gold crowns, a gold chain, and other valuable gifts. We may well

wonder if dice played any part in this. On the way home, Cardan saw to it that he visited, diagnosed and treated England's Edward VI who was in wretched health. The king asked the consultant for a horoscope, but the Milanese man of medicine had a dread of predicting events where the prognosis was obviously poor, and so refused. At any rate, in the sixteenth century, it was an unhealthy practice to make predictions, for kings, that failed to come to pass. Still on the way home, he was offered the post of court physician by the French king, Charles V, who was busy at the time blasting away at Metz. Cardan eventually got back to Milan after completing an itinerary through every large city of Europe.

His son, Giambatista, now caused trouble. The boy had impetuously married a prostitute and rid himself of his undesirable mate by means of a poisoned drink. Giambatista was tried and sentenced to death. Cardan spent almost all his money and talked himself hoarse before the senate in a futile effort to have the sentence changed from death to exile. The disgrace, expense, and physical effort left the father a broken and unpopular man.

In 1562, Cardan deserted his practice and returned to Milan where he remained idle until called to Bologna. Here he served as a professor for the next eight years. He was never a spirited and zealous practitioner, but regarded his calling, says Morley, like the Frenchman whom Cabot paraphrased as saying, "The study of medicine is heaven, the practice of it hell." On this point, Cardan declared, "If I had money to earn, I could earn it as a doctor, and in no other way. But that calling of all others (except the glory that attends it) is completely servile, full of toil, and (to confess the truth) unworthy of a high-spirited man, so that I do not at all marvel that the art used to be peculiar to slaves."

When he was almost three-score and ten, for some reason history does not clearly give us, Cardan was thrown into jail. Maybe it was some dice-game sleight-of-hand, or some charge of impiety, but it could not have been more than a misdemeanor, for 11 days later he was released, only to be placed in "house arrest" for three months and forbidden to publish any more books. To clinical purists who demand that the patient who is to be diagnosed as a psychopath reveal some history, no matter how slight, of friction with the law and subsequent imprisonment, we have this episode in Car-

dan's life to offer. Friends stepped in and whispered that perhaps Cardan's loss of popular esteem indicated exile. The aged doctor went to the Pope who provided an annuity for him. Now the physician had time enough to edit his works. He burned no less than 170, but left, as has been said, 131 published works and 111 manuscripts of which, says Morley, "not twenty have seen the light." Yet Cardan always advised would-be authors to "publish no crude books, they disarm you and pass over to the enemy."

At the ripe age of 75, Jerome Cardan breathed his last in Rome on September 20, 1576. The life of this man contains many interesting events and anecdotes; but what was he? Scholar and physician, or shrewd schemer and gambler . . . an intellectual psychopath?

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VOLUNTEERS IN MENTAL HOSPITALS*

BY MARJORIE H. FRANK

With Discussion

By Ethel B. Bellsmith

Many Red Cross staff members suggested titles for this paper. Since the trend to use volunteers more fully in hospitals is just becoming apparent, I think that the one I would choose from among their suggestions is "The New Look in Volunteers." As we women took some time to adjust ourselves to the "new look" in dresses, so I feel it will take time for professional hospital staffs to understand fully the capabilities and helpful resources of volunteers, and to acquire the knowledge of methods of successfully assigning volunteers to certain types of work in hospital programs, particularly in neuropsychiatric hospitals.

Therefore, it is a pleasure to discuss a field of work for volunteers in which I am deeply interested, and for which I feel there is such a vital need. Volunteer aid, besides being of definite help to the professional staffs in their work with patients in the hospitals, is one of the best methods to help educate communities to an understanding of mental illness, to appreciation of the conditions and needs of mental hospitals, and also to the acceptance of patients on trial visits or on their return to home communities—since members of these communities, by their interest and work in the hospitals, can be correct interpreters to the public.

There still seems to be varied opinion as to the desirability or value of volunteers in relation to the service they can give to a neuropsychiatric hospital.

From contact during the last six years with this field of volunteer work, the writer has come to realize that professional staffs

*Mrs. Frank's paper, "Volunteers in Mental Hospitals," is also appearing in the journal, *Mental Hygiene*. It is being printed in THE PSYCHIATRIC QUARTERLY SUPPLEMENT through the courtesy of the National Committee on Mental Hygiene. Mrs. Frank, who is director of Service in Veterans Hospitals, American Red Cross, North Atlantic area, read her paper before the section on mental health of the National Conference of Social Work, at Atlantic City, N. J., April 20, 1948. The article appears in THE SUPPLEMENT together with the discussion of it at the conference by Mrs. Ethel B. Bellsmith, supervisor of social work, Central Islip State Hospital, Central Islip, N. Y.

need as much interpretation on the utilization of volunteers to their greatest capacity as do volunteers in reference to the type of work and type of patient with whom they will be in close contact. The Veterans Administration realizes fully the usefulness of volunteers who either work in the hospitals or in the community for the good of the patient. They feel that the volunteer brings the patient closer to the community and therefore keeps the community aware of the conditions and operations of the hospital. To quote briefly from an article[1] by Dr. Daniel Blain, recently chief, neuropsychiatry division, Veterans Administration:

"With regard to the function of volunteers, we are operating on the principle that a volunteer plays an essential part in the total job of aiding in the recovery of a patient, that he has certain specific functions with regard to doing specific jobs with certain patients, and, in addition, he has general functions which have to do with the background, environment, and other connections of the patient before and after the treatment, and an important relationship to the community at large.

"In general, the volunteer worker parallels the work of the paid employee. I should mention here that those who come in as volunteers without salary and are, therefore, not in a formal employee status nevertheless are serving for compensation. The compensation in this instance is not financial, but it behooves everyone concerned with the volunteer in an administrative and promotional capacity to keep in mind the very important consideration of satisfaction, appreciation, and other forms of compensation which the volunteer worker must have if his work will remain steady and show gradual improvement.

"In general, salaried professional workers are subject to control and selection; certain training is demanded of them; and they have a certain amount of clear-cut responsibility and are subject to certain authority. In addition, they may live in hopes of certain advancement when their work is properly done. It is our belief that all volunteer workers should have the same feeling of responsibility toward their work, should live under the same authority, should be subject to certain types of control and be subjected to a program of selection and training parallel to that of salaried professionals."

To obtain volunteers readily who will really be good assistants

in a hospital program, the writer would suggest that the professional staff or a selected staff member first should survey the various hospital departments carefully to ascertain the number of volunteers that could be used to help the scheduled programs, or the expansion of these programs. This survey should also include the qualifications required of the volunteers to assist each department.

It should be noted that if volunteers with particular ability or interest serve a hospital, these volunteers, in most cases, will give regular and dependable service for many years. Red Cross experience has shown that volunteers who are, or have been, teachers maintain their interest in coming regularly to the hospital to teach selected subjects to patients. Volunteers versed in music continue to focus their attention on furthering this interest in the hospital. Volunteers interested in athletics, crafts, chess, camera and stamp clubs, seem to maintain their enthusiasm to a much greater degree than volunteers with no particular interests or avocations in their backgrounds. The personality of the volunteer also is important. One who is a wholesome, warm, outgoing person seems to encourage patient-participation much more readily and to get along well with other volunteers and the hospital staff.

Another important factor to insure the continued interest of volunteers is to understand that they wish to be busy the entire time they are on duty. It has been found that assignments must be planned in advance of these aides' arrival, and that these assignments should be based on a real need and on value to the patients, besides consideration of the particular abilities of the volunteers. Programs also must be arranged for daytime and evening use of volunteers and must be planned on a winter and summer basis since many activities vary substantially according to the season of the year. Assignment is not an easy matter but a most important one. This is particularly true in neuropsychiatric hospitals where there is a constantly growing program and where the great majority of patients are ambulant; these factors permit the stimulation of a great variety of activities.

Recruitment periods—planned for two or three times a year, one in October after summer vacations, one in January after the holidays, and one in early May to plan for the summer months where

different activities may be stressed—have been found the most satisfactory means to obtain the needed number of new volunteers.

The Red Cross has found it necessary to have two professional staff members in most of the Veterans Administration hospitals and even three or four in a few of the large hospitals, so as to maintain a smooth-running Red Cross volunteer program. Among this staff's main duties are: ascertaining the needs of the hospital departments, helping to recruit volunteers with particular aptitudes, and co-ordinating and planning, with the hospital departments and Red Cross chapters, volunteer orientation courses, schedules, programs and assignments. Just as important is their planning for in-service training and—as agreed upon with the various hospital departments—helping to supervise directly the Red Cross volunteers. The latter function particularly pertains to recreation, since nearly every ward has daily programs, and it has been found that helpful, continuous supervision, including in-service training, is of the utmost value in stimulating the volunteers' continued interest as well as new program ideas.

Here is a brief outline of the steps that we have taken to procure volunteers for Veterans Administration hospitals. These procedures were first undertaken for a Veterans Administration neuropsychiatric hospital about six years ago and not only are still successful in helping obtain new and able volunteers constantly for this hospital, but are just as successful in procuring volunteers for other neuropsychiatric hospitals.

First, the Red Cross field director at the hospital ascertains the needs of the various Veterans Administration hospital departments. She not only learns the type of service for which the volunteers are needed, but also the days of the week, hours of the day or night and the particular type of work the volunteers will be asked to perform. For example, the occupational therapy department might wish a volunteer on Mondays from 9 a. m. to 3 p. m. to instruct patients in ceramics.

Different age limits are usually found suitable for different types of hospitals. Younger volunteers, 21 to 45, seem best suited for work in general medical and in neuropsychiatric hospitals; volunteers from 25 to 50, for tuberculosis hospitals.

The field director notifies the Red Cross chapters in the communities serving her hospital, giving them the full details, and the chapters—either through newspaper, radio publicity, or, more successfully, through personal acquaintanceship and talks to different community groups—recruit the volunteers.

Chapters hold preliminary interviews where full explanations of the hospital, the patients, and the needs are given to prospective applicants.

Further interviews then follow with the Red Cross field director and with a member of the hospital staff to whom the volunteer may be assigned. Application forms completed by the prospective volunteers show the time they will be available, their reasons and qualifications for work in any particular hospital, and also a number of their main interests such as games, crafts or music. It has been found most helpful to have a psychologist or a psychiatrist at the hospital participate in the interviewing and selection of prospective volunteers, not only for neuropsychiatric hospitals or neuropsychiatric wards in general medical hospitals, but for all hospitals. Simple psychological tests usually are given and, although some volunteers may be rejected, the ones who are carefully selected and accepted are the ones who continue to work regularly and successfully, and who co-operate wholeheartedly with their fellow-volunteers, hospital staff, and patients. Those who, the hospital feels, are not suited for the particular hospital are then told by the Red Cross chapter of other services which they may perform for the Red Cross.

Dr. Florence Powdermaker, neuropsychiatry division, department of medicine and surgery, Veterans Administration, emphasizes the importance of careful selection of volunteers when she says:[2]

"Screening of the volunteer is important for the sick both from the standpoint of the patient and the volunteer. The volunteer will only get satisfaction and happiness from his work if he is suited in the first place for work in the hospital and if he is assigned to a job which is congenial and for which he has some gift or training. It is necessary for the patient that the volunteer be screened so that he will be assured of helpful ministrations from the volunteer. Working with the sick is an avocation or a profession for

which everyone is not suited however great the interest may be. It is in part a matter of temperament and personality. Not to be found acceptable, is in no way a reflection on the person but simply means his personality and talents suit him for a different kind of work. It aims to keep the round peg from a square hole. If done in this spirit, screening is not a problem and one can be assured of the cooperation of both the individuals and the organization."

All accepted volunteers attend an orientation course of about 15 hours in length. This course consists of a Red Cross chapter lecture, following which Red Cross hospital staff members and representatives of the various hospital departments participate in conducting a series of lectures, panel discussions, and tours of the hospital. A short examination follows and then a probation period of about 30 hours during which it can be ascertained where the volunteers would best fit in the hospital program and during which an evaluation is made of their interest and co-operation.

Volunteers are asked to promise to serve a minimum of 50 to 100 hours a year. In-service training is scheduled regularly so that they are always aware of changes or broadening of the hospital program. This training is planned by the Red Cross staff and the volunteers themselves. Hospital staff members often participate, giving detailed information as to their own departments.

The Red Cross is trying not only to encourage group recreation, such as that at parties and dances, but to stress as much individualized attention and individualized recreation as possible. This not only holds the interest of the volunteers but seems to be beneficial and pleasing to the patients.

A well-planned recreation program continues on a daily basis for all wards, even for the acute service, and an effort is made to stimulate volunteers to encourage patient participation to the highest degree, particularly on an individual basis. In other words, the volunteers try to start responsive patients playing games; and then the volunteers focus attention on the patients who seem to withdraw and do not wish to participate.

A great portion of in-service training, therefore, is focused on different types of games. Field directors and volunteers are always looking for new games which will interest the patients and which can be used in the recreation program. Besides individual

recreation, volunteers sponsor dancing classes, musicals, community singing, plays with patient participation, and various group activities such as chess and stamp clubs.

Volunteers are of great service to many departments in the hospital in addition to the recreation department. Selected as much as possible on the basis of their knowledge, some are assigned to the library, and besides helping in the regular routine—even covering the library at times in the absence of the librarian—they also read to patients and hold discussion sessions on various subjects. Again, there must be careful selection of readers or discussion leaders to hold the attention of a patient or group.

Volunteers show enthusiasm in the athletic program and participate in activities such as golf, tennis, croquet, badminton, softball, swimming, archery, fishing and skiing.

There are two types of craft program in Veterans Administration hospitals: occupational therapy and manual arts therapy. Occupational therapy differs from manual arts therapy in that it offers medically prescribed activities, determined by the emotional and physical needs of each patient, for purely therapeutic values. Manual arts therapy is directed toward the exploration, direction and preparation of the individual for vocational training and placement in an industrial or trade activity.

Volunteer recruits for these two departments, are not only interviewed at the community level by the Red Cross chapter, but also by a representative of a museum or craft school, to ascertain professionally the volunteers' qualifications and knowledge of particular crafts. Often the chapters will hold craft courses to train additional volunteers. After acceptance by the hospital and completion of the orientation course, these volunteers work under the direct supervision of the Veterans Administration occupational therapy and manual arts therapy departments.

Also, since many volunteers are used in the occupational therapy department, this department in many hospitals holds series of lectures and instruction courses as in-service training to broaden the knowledge of their skilled volunteers. Volunteers versed in ceramics, woodworking, metal and jewelry, painting, plastics, leather and weaving seem to be the ones most needed by the occupational therapy department.

There is an extremely wide range of craft work needed in a large neuropsychiatric hospital, as not only the degrees of skill of the patients or their potential abilities, but their mental states also must be taken into consideration. The Arts-and-Skills volunteer working with mental patients must have not only a thorough knowledge of her particular craft, but must have a stable and well-balanced personality. This work requires great patience and understanding, and sympathetic knowledge of the patients' illness. The work with some of the more regressed patients is on the level of kindergarten crafts. These patients will have a very short interest span. With such patients, the volunteers have found that adding music and gardening projects to the craft program has been most valuable in keeping interest at a high level.

Volunteers work in the occupational therapy clinics and also directly on the wards, not only with ambulant, but with infirm and bedridden patients. Here the workers must do a great deal of preparatory work, as many of the men are not able physically to handle some aspects of the projects. The program must be adapted to the special needs of wheelchair patients and those with certain other disabilities.

A report from one neuropsychiatric hospital where 179 patients are enrolled for courses in vocational subjects states:

"Besides assisting the Manual Arts Therapy department in teaching simple and artistic crafts, volunteers are used in this program also to assist in carpentry, cabinet making, upholstery, textiles, printing, machine shop, sheet metal, photography, electricity, radio, art leather, shoe and luggage repair, graphic arts including blue print reading and mechanical drawing, precision casting and art metal work.

"In the graphic arts and mechanical drawing shop volunteers are now teaching blue print reading, mechanical drawing, sign painting, lettering and design. In this shop as in many others, patients who are newly assigned by doctors' prescription may still be in some state of mental confusion. It is with these men that volunteer workers can be particularly helpful. These patients may require almost constant individual instruction for some time. Much as the instructors might wish to give a great deal of personal attention to these men it is impossible with the number of pa-

tients in the class to give all the individual instruction desired. But, with sufficient volunteer aid, much personal help can be given both to the patient who is a bit slow to learn as well as to the man who may advance quickly to a higher degree of skill than his fellow students.

"Volunteers who have been experts in dressmaking are now readapting their skills to fit the more commercial methods used in the textile shop. With a few lessons of instruction in operating power machines, rather than their home model and cutting dozens of garments from patterns at one time instead of the usual single dress, they prove to be of great help in this commercial sewing shop.

"In addition to these volunteers who serve regularly, specialists who can come to lecture on the job opportunities and latest methods in various trades are being located through the various chapters to talk to the patients. One of the local chapters stimulated the interest of the head of the graduate school of a local college of engineering, who visits the hospital regularly. Through the interest and contacts of just this one volunteer, arrangements are being made for teachers from vocational schools and local business experts to give lectures and help advise the patients in their future plans for study and job opportunities, after their discharge from the hospital.

"Many donated items are being collected for work in these shops. Radios in any condition are needed for use in teaching radio repair, and many dozens of these as well as small motors and many other items have been collected and donated to this program.

"The teamwork between the paid workers and the volunteer enables the hospital to give far more concentrated attention to the patients. Occasionally, in neuropsychiatric hospitals there will be a patient who is more antagonistic towards any paid staff member, feeling that they conspire against him. A patient of this type may be willing to trust the volunteer and respond to her suggestions (relayed from the professional staff) until he has regained confidance in the sincerity of the desires of everyone to help him recover.

"The volunteers themselves very often become so interested in their work that they continue to study and attend craft classes in their communities."

Another department to which volunteers are assigned is educational training. Patients may study any course in which they are interested and the Red Cross has recruited teachers for most of the requested subjects.

To quote again from another report from a Veterans Administration neuropsychiatric hospital:

"Volunteers have become of great value in developing rapport with patients, stimulating interest in the retraining area, and in general reducing a patient's tension and anxiety in merely being an objective and understanding audience to his problems. They guide and instruct individual patients in typewriting, shorthand, bookkeeping, business subjects, English, social science, and mathematics. The academic level runs from basic educational needs for illiterate patients through to college level work. Many volunteers are equipped with special interest and skills such as journalism, design and scientific backgrounds. Every opportunity is seized to enable a volunteer to employ this specialty in the program. For example, the specialty in journalism is promoting patient contributions for the local hospital bi-weekly publication. In addition to being a valuable supplement to the regular instructor staff, the volunteers have contributed a wholesome atmosphere by their daily presence in the classrooms. Patients respect the 'Gray Lady' uniform, they enjoy the daily association with people from 'outside.' The increased individual supervision results in a corresponding stimulus of a patient's feeling of being an individual—a goal in psychotherapy. This is evident by the patients' increased attention to their personal appearance, the spontaneous display of courtesy by some patients and by the gradual responsiveness of heretofore seclusive individuals."

We have found that it is not wise to recruit volunteers only interested in teaching, as many patients in a neuropsychiatric hospital will not be able to follow a daily or even weekly teaching routine. Therefore, it is well to select a volunteer who has a teaching background but who will be willing to work in other phases of the hospital program if patients to whom she could be assigned are

not available the day she arrives. We have also been able to use units of students from colleges who come regularly to some of the hospitals to study with the patients or to teach them.

Volunteers are assigned to the Veterans Administration nursing department to help feed patients, fold surgical dressings, mend and sew.

Other volunteers in the Red Cross chapters serving the hospital indirectly aid the nursing department by making articles for the patients such as sweaters, socks, pajamas, covers for crutch pads and hot-water-bottles, cushions and dayroom curtains.

Other Red Cross volunteers are members of the Canteen Service who, after taking a required Red Cross course, serve at teas and picnics, etc.

Another available volunteer service is that of the clerical workers for the different hospital departments. A few instances where these volunteers assist in Veterans Administration hospitals are as follows: social service, chaplains, special services, recreation, athletics, library, various departments under physical medicine, rehabilitation, dietetics, and clinical records. They also help edit and set up the hospital newspapers or magazines.

Medical service in many of the hospitals asks for volunteers to be directly assigned to individual psychiatrists for special types of work with certain patients. Gray Ladies taking active roles often participate in psychodrama and they are active in planned group psychotherapy gatherings which are closely supervised by the psychiatrist in charge. Under the supervision of the psychiatrist they help in the postoperative education of the leucotomy patients on a daily basis. Reports from the psychiatrist and the volunteers in this particular duty are most enthusiastic. Volunteers work on the acute intensive treatment service and also assist in the electric shock and insulin therapy programs. They play music, play simple games, converse with patients before their shock treatments and assist in the feeding after shock treatments. In a psychiatrist's letter[3] to the Red Cross, he says: "In the insulin service, patients emerging from coma frequently pass through phases of early life. In these, one man needs a smiling face; another a soothing maternal voice and hand. In all, the re-establishment of contact with reality is made easier, and a wholesome return is favored

by the presence of Gray Ladies. Another part they play here is the selection of suitable record music to provide an easy and emotionally satisfying awakening.

"In the electro-therapy service, too, patients awaken from a period of unconsciousness, through helplessness to full awareness. Again the Gray Ladies, with music, with refreshments, with their kindness and interest provide a setting which favors the wholesome reintegration of a personality.

"In the psychosurgery program, which is rather intensive at this hospital, the interest shown by the ladies who have devoted themselves to this program has resulted in what might well turn out to be a major contribution. With a thumbnail sketch of the patients' personality and the problem presented, these ladies have developed an educational program, which begins with elementary speech mechanisms, advances by degrees through the uses of vocabulary, symbolic constructions, up to the ways of the outside world in everyday life, correct manners and practices in ethical reasoning. As we know how far from accepted customs the patient is who has been approved for leukotomy, and how great is his need of re-education, we look upon the program of the Gray Ladies with warmest approval."

Volunteers also have successfully assisted the social service department in its work with the patient. The following list of specific kinds of duties performed by Red Cross volunteers in conjunction with, and under the direct supervision of, social service workers is reported by one of the hospitals: "They make initial contact with new patients to inform them of the general functions and availability of Social Service; help patients fill out forms for clothing requests, insurance blanks, application blanks, etc.; help patients write letters to relatives in matters pertaining to Social Service; perform contact work on all request items such as wheelchairs, eye glasses, etc., as a follow-up on the original contact; and under the direction of Social Service workers, contact patients on the ward who need an opportunity of talking with someone when they are especially low and lonely, with a view toward referral to the social worker of any case work problem. This could be termed 'Companion Service.'"

The writer has seemed to focus most on the work of women in this paper. However, many men volunteers have been recruited to participate in programs in neuropsychiatric hospitals. In one such hospital, over 100 men are now serving; and, besides working in the occupational therapy, manual arts therapy, and educational training departments, men volunteers are actively participating with women volunteers in sports activities with the patients at the hospitals and very often in the communities. Men and women volunteers serve in various patient clubs, such as stamp, chess, and book. They also plan forum discussion groups and dramatics, with volunteer and patient-participation under the supervision of a hospital staff member.

Besides the volunteers who serve on a regular basis, there are those who occasionally act as hosts and hostesses for parties and dances, and entertain on the wards or in the auditorium. Many dances could not be held without the attendance of girls from the community. These volunteers who serve only on an occasional basis receive a brief orientation by the Red Cross hospital staff on hospital policies and the neuropsychiatric patient. It has not seemed necessary for these particular volunteers to participate in the entire screening and training process discussed in the foregoing, since they are at the hospital on very few occasions and have constant supervision.

The number of volunteers required to fulfill the needs grows constantly as the different programs expand. At one hospital, the Red Cross has over 400 volunteers a month and is still recruiting more. All of these are capable, trained volunteers, giving regular service. They come from distances of five to 50 miles.

One of the principal contributions volunteers make is to help the patient feel he is one of a community. Community participation is needed to foster a patient's interest in community activities. The Red Cross Motor Service transports patients from the hospital on sightseeing trips, to picnics, to baseball and football games, to plays, and to other forms of activity such as bowling, skiing, tennis, and dancing classes in the community. Visits to industries have resulted in many patients acquiring jobs in the community. Also, many patients attend meetings of the Rotary, Lions Clubs and other organizations, and have entered into civic contests such

as the "model home" contest. Quiz programs on the radio, with joint patient and community participation, seem to be enjoyed by community members and patients alike.

Many organizations, as well as schools, colleges, and other educational institutions, also are of great service in contributing material supplies, since many people cannot give time to work at the hospitals but wish to show their interest in the patient.

To summarize briefly, the writer would say that for in-hospital work—in order to utilize fully and successfully volunteers who will be of real aid to the patient and hospital staff and who will enjoy continuous participation in their work—there must be careful selection and training and a well-planned co-ordinated program which must be kept on a continuing, organized, and growing basis.

Also, by the volunteers' close relationship with patients in neuropsychiatric hospitals, a better interpretation and understanding of neuropsychiatric disability is brought to members of the community. This personal interpretation by a hospital volunteer who is at the same time a member of the community is, I feel, one of the best ways to disseminate more useful knowledge of mental illness to the community.

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DISCUSSION

By Ethel B. Bellsmith

It is a pleasure to discuss the paper so ably prepared and presented by Mrs. Frank. My experience as field director of the American Red Cross at Mason General Hospital in 1944 and 1945—with over 3,000 volunteers, including 500 Gray Ladies, and large groups in Arts and Skills, the Canteen Corps, and Motor Corps—

as well as our current relationship at Central Islip State Hospital with a relatively small group of Gray Ladies and Canteen Corps volunteers, forms the basis of my comments. Mrs. Frank's statements regarding the possibility of educating the community to an understanding of mental illness, the conditions and the needs of mental hospitals and the acceptance of patients on their return to the community are entirely valid. Further, volunteers as representative citizens of the community and as taxpayers, should be informed of the conditions in mental hospitals, the aims of treatment and the facilities available. In addition to the definite services given to the patients on an individual basis and as a group, and in addition to the knowledge of the hospital program communicated to the community, the volunteers, because of their interest and connections, are an excellent route through which special donations are channeled to the recreation, occupational therapy and library programs.

There is no question that members of the professional staff of a mental hospital who have had no previous experience with volunteers need interpretation as to the capacity of the volunteers who are assigned and the duties for which they are best fitted. I am, of course, in complete agreement with Dr. Blaine's statement on volunteers.

After the needs of the hospital have been surveyed as to the number and kinds of volunteers to be used, the important question is how to get enough volunteers for the opportunities available. It is understood that the military and veterans hospitals have the first call on the volunteers able to serve. It is further recognized that the nature of the appeals necessary to stimulate volunteer service at this time will be somewhat different from those which activated volunteers during wartime. The necessity for careful selection, training and orientation is emphasized. Mrs. Frank's statement about the additional benefit to the patient of volunteers who have special skills and training is unquestioned.

We cannot give too serious attention to the necessity of planning for all volunteers in advance and the assignment of specific duties and responsibilities, recognized by them, by the patients, and by the staff as being important and essential.

The author gives the preferable age of volunteers for neuropsychiatric hospitals as from 21 to 45. Gray Ladies up to the age of 60, in my experience, have unusual assets and have been exceedingly helpful. Age, experience in living, appearance and attitudes are definite assets.

We are thoroughly in sympathy with Dr. Powdermaker's statement that "working with the sick is an avocation for which everyone is not suited." Her view re-emphasizes the need for careful selection and assignment of duties.

The volunteers contribute to the care of the patients over and beyond their specific duties, responsibilities and donations, and their liaison between the hospital and the community. They not only, as Mrs. Frank states, contribute to the wholesome atmosphere of the hospital, but increase the patients' enjoyment of any activity —for several reasons. The volunteers come into the hospital from the community, they come in uniform, they come voluntarily and regularly. The patients are impressed with the fact that they are not paid members of the hospital staff. Their individual, genuine interest is encouraging and stimulating to the patients, adding to their interest in getting well, making them feel closer to the community and to their homes. The presence of volunteers from the community on the wards stimulates the hospital personnel to give better service to the patients.

Canteen Service, by serving refreshments provided by the hospital, works exceedingly well with Gray Ladies service and frees the Gray Ladies for more individual attention to specific patients.

There is a great need for the assignment of members of Arts and Skills to state hospitals and we are hoping that groups may eventually be available to assist in occupational therapy classes. In addition to the need for volunteers in the usual crafts and skills taught in occupational therapy in mental hospitals, there is a real need for persons proficient in several languages to teach elementary English to foreign-born patients, particularly to Puerto Ricans. Trained volunteers can be valuable adjuncts in group therapy, group activities and dramatics.

Greater interest in ward activities and the patients' part in these smaller groups increases the number of volunteers required. A real danger in a very large hospital is that the needs of an indi-

vidual patient may be overlooked. The ward personnel, too few in number, concentrate on the problems presented most insistently for their attention. The quiet, seclusive, well-behaved patient is in even greater need of our help than the demanding or disturbed one. To him, the volunteer is of very real service.

There is no doubt, in my opinion, of the very beneficial aspects of a volunteer program in a mental hospital. Social workers have welcomed eagerly the present opportunity to indicate the unique and beneficial aspects of the volunteer program and our appreciation of the contribution of the American Red Cross in providing this service. It is our earnest hope that a steady expansion of the program to all mental hospitals may be anticipated.

Central Islip State Hospital
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THE WORK OF CONSCIENTIOUS OBJECTORS IN STATE MENTAL HOSPITALS DURING THE SECOND WORLD WAR

BY ROBERT A. CLARK, M. D., AND ALEX. M. BURGESS, Jr., M. D.

When business began to improve with the re-armament program in the late 1930's state hospitals began to lose their attendants. This trend was accelerated with the war, until by 1942 many hospitals were in desperate need of personnel. At the same time, many conscientious objectors, judged by their draft boards as sincerely opposed to military service on religious grounds, were being placed by Selective Service in what were called Civilian Public Service camps under civilian direction, doing work considered to be of national importance. Many of the men were dissatisfied with activities such as tree-planting, because they wished to be doing something more intrinsically interesting or more significantly humanitarian. When the opportunity came—through the collaboration of Selective Service, the American Friends Service Committee, the National Committee for Mental Hygiene, and the superintendents of several state hospitals—for conscientious objectors to volunteer for work as attendants, many gladly accepted. Their maximum compensation for this work was only to be maintenance plus $15 per month.

The first units were started in 1942 at Eastern State Hospital, Williamsburg, Va., and at Philadelphia State Hospital in Pennsylvania. Before long approximately 2,300 conscientious objectors were working in 39 hospitals in 19 states. Approximately 4,000 individuals served during the war. The Brethren and Mennonites joined the Friends in helping to administer these units. Gradually other denominations, including the Methodists, Evangelical and Reformed, Disciples of Christ and Baptists, became interested. One unit, at Middletown, Conn., was taken over directly by Selective Service Headquarters.* See Tables 1 and 2.

The men worked principally as attendants, but many also spent considerable time in other capacities. Several were physicians, and helped to relieve the frightful professional shortage. At East-

*Many conscientious objectors also worked in state schools for mental defectives, and in veterans' mental hospitals. In addition, many of their wives worked as attendants or in other capacities at the hospitals.

Table 1. Hospitals Served

Colorado:	Colorado Psychopathic Hospital
Connecticut:	Connecticut State Hospital, Middletown
	Fairfield State Hospital
	Norwich State Hospital
Delaware:	Delaware State Hospital
Indiana:	Logansport State Hospital
Iowa:	Cherokee State Hospital
	Independent State Hospital
	Mt. Pleasant State Hospital
Maine:	Augusta State Hospital
Maryland:	Eastern Shore State Hospital
	Spring Grove State Hospital
	Springfield State Hospital
Michigan:	Kalamazoo State Hospital
	Ypsilanti State Hospital
New Hampshire:	New Hampshire State Hospital
New Jersey:	New Jersey State Hospital, Greystone Park
	New Jersey State Hospital, Marlboro
New York:	Hudson River State Hospital
Ohio:	Cleveland State Hospital
	Columbus State Hospital
	Dayton State Hospital
	Lima State Hospital
	Hawthornden State Hospital
Pennsylvania:	Allentown State Hospital
	Harrisburg State Hospital
	Norristown State Hospital
	Philadelphia State Hospital
	Warren State Hospital
	Wernersville State Hospital
Rhode Island:	Rhode Island State Hospital for Mental Diseases
Utah:	Utah State Hospital
Vermont:	Brattleboro Retreat
Virginia:	Southwestern State Hospital, Marion
	Western State Hospital, Staunton
	Eastern State Hospital, Williamsburg
Washington:	Western State Hospital, Ft. Steilacoom
	Eastern State Hospital, Medical Lake (unit discontinued)
Wisconsin:	Winnebago State Hospital

Table 2. Denominations Supervising Hospital Units

Mennonite	20
Brethren	8
Friends (Quakers)	6
Others (1 each)	4

ern State Hospital in Williamsburg, Va., three physicians worked throughout the war. Others held various technical positions such as those of laboratory and x-ray technicians, social workers and occupational therapists. Still others did skilled work as cooks, firemen, barbers, clerks, radio repairmen, carpenters, dairymen and farmers. Hospitals varied in the types of positions to which they assigned the men—some adventurous administrators tried them wherever their previous training or present talents suggested; other restricted them almost entirely to attendant placement or other comparatively unskilled and menial work.

Because of these variations, a great many of the skills and talents available were not fully used—or were completely untapped. As a group, the conscientious objectors were well above the average in intelligence, education, and job classification. In the units under Friends' administration, for example, the men averaged 15 years of formal education—three years beyond high school. Of 272 men, 42 were teachers, mostly in colleges and high schools, and 15 were college students, nearly all preparing for professions. Of the rest, 69 were capable of other professional work, ranging from research scientists, engineers and lawyers, to artists, musicians and radio writers. Many others were skilled or clerical workers whose skills were seldom used throughout the war.

Besides intelligence, education and skill not often found, most of these men brought to their positions a high level of idealistic humanitarianism. Since they volunteered for hospital service, they were largely self-selected. As they were at the bottom of the state hospital hierarchy, they had unparalleled opportunities for continual and close observation. They contributed, therefore, much more than their direct work.

Most of these men found themselves thrust into wards occupied by active or physically-ill patients—with little or no instruction or guidance in what to do except for hurried directions or comments from supervisors sometimes less educated and less humanitarian than they. Realizing the size of the job and their own inadequacy, the objectors began asking for courses of instruction in the principles of psychiatry and of nursing. Insofar as limited personnel permitted, these requests were granted in many hospitals. At Philadelphia State Hospital, for example, a two-day orientation be-

fore assignment to special duty was instituted, and new assignees had a series of lectures by doctors and nurses. Where such courses were not given, or to supplement what was offered, the men usually organized their own classes or, where books were available, studied "on their own." Realizing that many other attendants and other state hospital workers were suffering from the same handicaps as they, a group of conscientious objectors began to collect and organize the information and practical techniques they had learned and developed, with the intention of passing them on. To carry on this work, as well as other projects soon to be described, the Mental Hygiene Program of Civilian Public Service was organized. The program circulated among the conscientious-objector units a mimeographed exchange service for the dissemination of experiences and ideas. It published a monthly magazine centered about attendants' problems, at first called *The Attendant*, now, *The Psychiatric Aide*. The organization wrote and had printed a *Handbook for Psychiatric Aides* containing elementary expositions of psychiatric disorders and their treatment. These publications were well received in many institutions; large numbers of copies were ordered for distribution throughout hospital staffs. Nor did the Civilian Public Service men stop with their own immediate tasks. Wishing to put their special training to work, they organized, under the guidance of the Mental Hygiene Program, studies of mental hosital architecture and of laws dealing with mental patients in different states.

At first the conscientious objectors were received with some skepticism; but, as time went on, their work obtained wider recognition. Partly because of feelings often shown by other attendants, the Civilian Public Service men were sometimes segregated in one shift or one building. In one hospital, for example, the entire day shifts on the infirmary and receiving wards were taken over by these men.* At Williamsburg, Va., the entire male side was handled by Civilian Public Service men for some time. In most hos-

*Since 1943, women have been serving voluntarily in several mental hospitals under the auspices of the American Friends Service Committee, and more recently, under the Mennonite Central Committee and the Brethren Service Committee. A number of these women are wives of Civilian Public Service men. Since the expiration of the Selective Training and Service Act of October 1940, men have also been serving voluntarily. Not all of them are pacifists.

pitals, as the zeal and capability of many of the men were recognized, they were gradually reclassified from their original menial tasks to ones requiring greater skill and responsibility—though at no higher remuneration. Many superintendents made very favorable reports on their work, commenting on marked reductions in the use of restraints and in the numbers of injuries. Only in two hospitals was Civil Public Service help discontinued; and, in one of those, it was reinstituted. *The Psychiatric Aide* and the handbook for attendants were distributed to many more hospitals than those where Civilian Public Service men were stationed. From the start of the Mental Hygiene Program, more and more attention began to be paid by psychiatrists outside the institutions and by the general public. The support and encouragement of the National Committee for Mental Hygiene was gained. Selective Service released several men for full-time work with the program.

In order to learn more fully from the superintendents of the mental hospitals served their evaluation of the service, a questionnaire was sent to all 39 of them. The questions were:

1. How did their service compare with that of the average prewar attendant? Equal to.....Better.....Worse.....?
2. Did any special difficulties arise concerning them during their period of service (apart from purely administrative problems), and if so, what?
3. Was their presence in the hospital on the whole stimulating or detrimental to its management? Could you expand on the reasons for either opinion?
4. If a similar emergency were to arise, would you be willing to have conscientious objectors work in your hospital again?

Replies received from the 28 questionnaires which were answered have been tabulated in Table 3.

Table 3

Question	1	2	3	4
(a) Favorable	15	15	16	21
(b) Neutral	9	6	4	3
(c) Unfavorable	4	7	8	4
a minus c	11	8	8	17

Three superintendents gave uniformly unfavorable replies, while all of the answers of eight of them were commendatory. Two others answered three of the questions unfavorably, whereas seven gave unqualifiedly favorable answers to three questions.

Individual comments were varied and often contradicted other statements. Those favorably inclined used such adjectives and phrases as "diligent, conscientious, well-behaved and efficient"; "quiet, industrious, polite"; "better-educated, more sympathetic, better personal habits"; "kind to patients, interested in their work"; "intellectually, culturally above the average"; "high intelligence and higher social standards." One superintendent laconically wrote: "They did not drink." Several stressed co-operativeness: "willing to work at any job"; "conducted themselves well and carried out their tasks willingly." The effect on other employees was mentioned: "Their humanitarian attitude assisted materially in changing the general cultural level of our attendants"; "Beneficial effect on language, work and conduct of other attendants"; "By example they elevated the standards of attendant patient care." Several mentioned the value of constructive suggestions and criticisms. These favorable comments were at times limited to groups or individuals, varying from such statements as "a vast majority were co-operative" and "there were many splendid men," to "individually several men quite stimulating and helpful." Two superintendents were of the opinion that the work was better in the early part of the service than it was later on.

Unfavorable statements ranged as follows: "rather rigid and uncompromising attitude"; "insufficient resourcefulness, initiative and sense of responsibility"; "Some attempt to shift the burden to others, precipitous in their thinking and tend to agitate"; "a lawless and ruthless group—beyond all discipline." Specific criticisms such as these were made: "continuously letting patients escape through their negligence"; "leaving ward . . . and elevator doors unlocked . . . leaving wards unattended . . . striking and injuring male patients . . . failure to assist regular attendants when attacked by patients"; "very poor housekeepers both in their own quarters and on the ward"; "several worked long at war-swollen farmhands' pay then . . . sleeping on night duty"; "did not co-operate with other employees well." The religious

outlook of the Civilian Public Service men was occasionally considered a problem, but only temporarily: "Occasionally because of religious beliefs difficulties arose . . . gradually straightened out when men discovered that on occasion destructive and combative patients have to be restricted." Lack of emotional stability in some men was mentioned: "some psychotic, several psychopathic"; "higher incidence of neurotic manifestations"; "most men had personal problems as a result of which they were continuously wanting time off to go see about their families." A few reports indicated hypersensitivity by authorities to criticism: "very free to offer opinions as to how things should be done, although they had inadequate knowledge or experience." Some mention was made of difficulties among the Civilian Public Service men themselves: "Six of them staged a sit-down strike because one of their members was returned to camp . . . refused to listen to pleadings of own companions and had to be removed from hospital"; "antagonism toward certain individuals they felt were not participating actively in the social life of the conscientious objector group but preferred to carry on their religious or other interests by themselves."

Many of the replies contained suggestions and statements which were constructive and gave insight into methods of handling some of the troubles just mentioned. Better selection was emphasized with more control over dismissal: "Impossible to make a positive selection . . . difficult to dismiss or replace inferior members"; "would suggest they be screened to avoid over-emotional and those with bitter resentment." The importance of good leadership was brought out: "While we had strong leaders we had no particular difficulties. When weaker characters were leaders we had frequent 'crises' which would not amount to much." Complaints from townspeople at times caused difficulty: "A few working away from the hospital at odd times and the American Legion constantly sent in reports about them. Suggest . . . education bulletins and newspaper publicity for . . . educating agitators who complained bitterly against the conscientious objectors"; "complaints from townspeople . . . Some of the liberties, such as living in town, had to be curtailed." The significance of the Civilian Public Service men's own attitudes shows up in the following:

"Resented by a great majority of employees. After a time many of these resentments overcome, especially when the conscientious objector had a pleasant manner and was a good worker." One hospital mentioned an arrangement valuable for stimulating interest: "An education course was given and they received college credit for their studies here."

Very soon after they began working it became obvious to the Civilian Public Service men that not only was their own orientation and training insufficient, but also that the care of the patients was woefully inadequate in nearly every respect. This inadequacy resulted in almost general neglect and not infrequent brutality. There was overcrowding into old and dangerous buildings. There was absent (in many hospitals) a minimum standard of medical care, and nowhere was there an approach to the maximum medical need, because of shortages of doctors, nurses, and other professional workers, and shortages of medicines and medical equipment. Consequently even good custodial care was seldom being given. Though these conditions were accentuated by the war, it was evident that in many institutions much the same state of affairs had existed before and would continue afterward. In some hospitals, conditions were worse than in others, but in none were they ideal.

First the Civilian Public Service men began comparing notes among themselves, then seeking methods of reaching the public with their findings. Articles began to appear in newspapers and magazines, written or inspired by conscientious objectors and often illustrated by pictures taken by them. Sympathetic superintendents often helped with, or gave permission for, these articles. That in *Life* for May 6, 1946 received most attention. Others appeared in the newspaper *P. M.*, in the magazine *U. S. Camera* and elsewhere.

The event probably most far-reaching in its effects was the publication in the Cleveland *Press* of a series of articles concerning the Cleveland (Ohio) State Hospital. Discovering unusually bad conditions there, the Civilian Public Service men at first complained to their supervisors, then to the physicians and superintendent. Getting only rebuffs, they carried the story to the newspapers in articles written by Walter Lerch, one of the *Press'* re-

porters. Dr. D. R. Sharpe of the Cleveland Baptist Association first became the leader of a grand jury investigation and then of the revitalized Ohio Mental Hygiene Society. The hospital had the conscientious objectors removed from the institution by Selective Service; but a thorough shake-up of administrative personnel followed as public pressure increased. After the reorganization, a new Civilian Public Service unit was installed in this hospital. Dr. Frank F. Tallman of Michigan, formerly of the New York State hospital system, was brought in to lead the reorganization of the state hospital system from top to bottom. Large new appropriations (though still not enough) were obtained from the legislature. New receiving hospitals, such as the one at Youngstown, are being opened throughout the state in major population centers so that mental patients will not have to remain in jail over nights, week-ends and holidays, awaiting commitment.

The leaders of the Mental Hygiene Program of Civilian Public Service recognized, as the war drew to a close early in 1945, that after they left the hospitals many of the gains that had been made would be lost, if a permanent organization were not founded. The most difficult wards, such as the ones for disturbed and infirm patients, where these men had often chosen to work, would again be in charge of poorly-trained attendants in altogether insufficient numbers. Projects in recreation and rehabilitation started with enthusiasm during the war would be abandoned. Surveys of conditions and of laws would never be completed. Therefore, the National Mental Health Foundation was organized as a continuation of the Mental Hygiene Program of Civilian Public Service.

The National Mental Health Foundation is an incorporated membership organization with offices at 1520 Race Street, Philadelphia. The national chairman and president pro tem for the first year was Owen J. Roberts, former associate justice of the U. S. Supreme Court. The staff officers are all former Civilian Public Service men, except for the staff psychiatrist. Many prominent medical men and women are among the sponsors and advisers, including Drs. Adolf Meyer, Thomas Parran, Gregory Zilboorg, Lauretta Bender, Earl D. Bond, R. H. Felix and Karl Menninger. In addition well-known persons apart from medicine have given their support, such as Pearl Buck, Harry Emerson Fosdick, Sheldon

Glueck, Henry R. Luce, William Green, Walter Reuther, and Eleanor Roosevelt.

The foundation is continuing much of the work done by the mental hygiene program. New pamphlets and leaflets have been published to further public knowledge of the need for better care for the mentally ill. Notable among these is George Thorman's *Toward Mental Health,* published as a Public Affairs Pamphlet. The magazine *The Psychiatric Aide* is being published as before, and it and the handbook are being widely circulated; 4,000 copies of the former go each month to more than 600 mental institutions. The survey of laws dealing with mental illness is being continued, as a joint project with the National Committee for Mental Hygiene. The state laws of Kansas, California, Wisconsin, Pennsylvania, South Dakota, Iowa, Massachusetts and Illinois have been summarized. A model law is also in preparation. This work has been done by 45 persons or more, including not only Civilian Public Service men doing work in mental hospitals, but also a number engaged as volunteer subjects (so-called "guinea pigs") in medical research, and members of the women's unit at Philadelphia State Hospital. When legislatures are in session model laws will be introduced in many states, and efforts made to get larger appropriations and other more adequate provisions for mental hospitals. The foundation is collaborating with local mental hygiene societies and other organizations interested in the question (such as the Public Charities Association in Pennsylvania). Its representatives are going about the country getting in touch with such groups and with interested individuals, to collect funds, to obtain outlets for literature, and to give addresses on the conditions in mental hospitals and the work of the foundation. Recordings of addresses and dramatic sketches concerning the care of the mentally ill have been prepared. They have been broadcast from many radio stations throughout the country.

Comment

Civilian Public Service contributed to mental hygiene both by its immediate efforts, and by more remote results. The actual work of the conscientious objectors themselves lessened the deleterious effects of the manpower shortage on the care of mental pa-

tients. If their skills had been more generally used, their contribution would have been greater. Personality defects in a minority of the men—and long hours over extended periods, in undermanned wards crowded with difficult patients—detracted further from the potential contribution. Despite these impediments, the men were able to give a greater quantity and a better quality of care to many patients than the patients otherwise would have received. Many hospitals were able to resume treatments and occupational and recreational programs which had been discontinued. In many hospitals restraints were used less often, accidents were less frequent, and in general, a more humane level of care was maintained. Encouragement was given for raising the standards of training of attendants in several of the hospitals in which the conscientious objectors themselves worked, and, by means of their publications, in other hospitals as well.

Judging by the opinions of the superintendents, the quality of service and the raising of standards varied from hospital to hospital. In a majority, high standards were maintained. In a minority, presumably because of poor selection of men, poor leadership, disunion and dissatisfaction among the men, and perhaps because of lack of adequate external incentives, the quality of service was, except for the work of a few, inferior. Consequently, in these hospitals, discounting the possibility of bias on the part of some superintendents' reports, the humane objectives of Civilian Public Service were not carried out so well as they were in the others.

For the first time (in many hospitals) intelligent, educated, and humane observers were placed on the wards of mental hospitals, at a level at which close and prolonged observation of hospital affairs was possible. It was inevitable under these circumstances that further developments should take place. The first of these more remote effects was the awakening of the workers' interest in the problem of adequate public care of the mentally ill. With this awakening came a desire for action, followed by the appearance of leaders who recognized the need and made plans to meet it. Soon publicity concerning the conditions in public mental hospitals began to appear and to spread—first to the objectors' own families, churches, and religious organizations, then to the general public through newspapers and magazines. Then came a more

organized effort to obtain better conditions—as knowledge of the possibilities increased—by reaching community leaders, legislators, and a larger proportion of the public. Before very long, actual improvements were made in some localities in the form of changes in administration, and larger appropriations. More developments of this type are in prospect, through the influence of interested non-partisan individuals and groups of both legislative and executive authorities. Since so many of the Civilian Public Service men are now, or are soon to be, professional men—doctors, lawyers, teachers, engineers—they should be an influential nucleus of such interested individuals.

If prospects are to be realized, if present gains are to be held, and if further progress is to be made, public interest and vigilance must be kept aroused. Sporadic campaigns arising from scandalous conditions cannot be relied upon to keep up high standards permanently. The National Mental Health Foundation was formed to help bring about this long-term result, with the continued aid both of professional groups and of much of the lay public. It is expected that changes in the administrative organization of departments of mental health and of welfare, and changes in commitment laws will further this end.

Summary and Conclusions

In lieu of military service, conscientious objectors served many mental hospitals well during the Second World War. Their service is continuing through the activities of the National Mental Health Foundation. With compulsory military service in the United States, particularly in case of any manpower shortage, alternative service of a similar type might be inaugurated for men who feel they cannot conscientiously undergo the military service period. Under such a plan, however, they should be paid—or equivalent funds should be set aside for charity—so that their labor will not compete unfairly with that of other hospital workers. If the men were paid, they would not then try to get work outside the hospitals on their time off. Their hospital work would not be interfered with, and the not unjustified complaints from the community concerning outside work would be stilled. Further suggestions for improving the service are as follows: improved screen-

ing so that the emotionally unstable would not reach the hospital; the facilitation of transfers of those developing maladjustment after arrival; good leadership to lessen conflicts among the men; the offering of training courses, either with college credit or leading to promotion to positions where intelligence, interests and skills would be better employed; and more public education as to the purpose and reasons for Civilian Public Service for conscientious objectors. State hospitals might then be closer to meeting the higher standards now recommended by the American Psychiatric Association.

Regardless of whether this is done, hospitals certainly should use every possible means to attract and keep a high grade of personnel, especially at the attendant level. Measures needing serious consideration are higher wages, shorter hours, better food and living quarters, promotions for completion of training courses and satisfactory service, accommodations for wives and children, and good medical care. In addition, frequent and thorough inspection of hospitals by disinterested, alert and trained men is necessary so that conditions such as were uncovered by Civilian Public Service would not go so long unpublicized, or would never even develop. If Civilian Public Service is able to claim some responsibility for progress in the mental hospitals, its members would feel that the time and labor they contributed were justified.

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A STATISTICAL STUDY OF FIRST ADMISSIONS WITH INVOLUTONAL PSYCHOSES TO HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE

BY BENJAMIN MALZBERG, Ph.D.

The population of the State of New York has been growing older, though not so rapidly as has been frequently asserted. In 1920, for example, 29.1 per cent of the population was aged 40 years or over. The percentage grew to 31.2 in 1930, and to 37.0 in 1940. If we draw a line at 50, we find that the percentage aged 50 or over increased from 16.5 in 1920 to 21.9 in 1940. Finally, if we draw the line at 60 or over, as is usually done in discussing the aged, we find that this group included 7.7 per cent of the population in 1920 and 10.7 per cent in 1940. The process of aging had consequences in relation to first admissions with mental disease in New York State.

In 1920 there were 3,377 first admissions to the civil state hospitals who were aged 40 or over, representing 51.4 per cent of the total. By 1940 this grew to 8,219, or 63.3 per cent. This trend has continued, so that in 1946-1947 there were 8,802 such first admissions, or 65.1 per cent of the total. If we consider the group aged 60 or over, we find that such first admissions increased from 1,291 in 1920 to 4,180 in 1930, to 5,168 in 1947, and represented 19.6, 32.2, and 38.2 per cent, respectively, of total first admissions in these years. It is known that this upward trend is associated primarily with a growth in admissions with psychoses with cerebral arteriosclerosis, and to a lesser degree in increased admissions with senile psychoses. But a similar growth in admissions with involutional psychoses has not received adequate attention.

There has been a remarkable growth in the prevalence of this group of psychoses as measured by first admissions to the New York civil state hospitals. Table 1 shows such first admissions from 1911 to 1947. Beginning with a total of 143 in 1911, there was a steady growth to a total of 941 in 1947. Relative to all first admissions, there was an upward trend from 1911 to 1922. At the beginning of this period, first admissions with involutional psychoses represented approximately 2 per cent of the total. By 1922 they included almost 4 per cent. This was followed by a downward

trend lasting until 1929 and 1930. Since the latter year there has been a very rapid growth in these disorders. In the case of the males they represented 4.7 per cent of all first admissions in 1946-1947. In the case of the females, they represented 9.1 per cent. When this statistical series was begun, more than three decades ago, the involutional psychoses were exceeded in prevalence by the senile psychoses, psychoses with cerebral arteriosclerosis, dementia præcox, general paresis, the alcoholic psychoses, and manic-depressive psychoses. Today they are exceeded only by the first three groups. They exceed the others by from 20 to 40 per cent.

The rates of first admission per 100,000 population rose slowly between 1911 and 1922, and then decreased moderately until 1930. Since the latter year, there has been a very rapid growth, especially in the case of females. Among the latter, the rates rose from 2.4 per 100,000 female population in 1930 to 9.2 in 1944, an increase of almost 300 per cent. The rate dropped in 1945, but has risen in the following years. Among males the rate rose from 1.0 per 100,000 male population in 1924 to 3.6 in 1940. After a decline to 2.5 in 1942, it rose to a maximum of 4.4 in 1947. The rapid general increase in the prevalence of the involutional psychoses during the past two decades is exceeded only by that shown by psychoses with cerebral arteriosclerosis.

The data in Table 1 show that the rates of first admissions with involutional psychoses are from two to three times higher among females than males.

There were 17,469 first admissions to all state and licensed hospitals for mental disease in New York State during the year ended March 31, 1947. Of this total, 1,394, or 8.0 per cent, represented involutional psychoses. Of the latter total, 941 were admitted to the civil state hospitals, 3 to the two hospitals for the criminal insane, and 450 to the licensed hospitals. The selective nature of these admissions is indicated by the fact that they represented 11.8 per cent of total first admissions to the licensed institutions as against 7.0 per cent of the admissions to the civil state hospitals, and 2.0 per cent in the case of the criminal insane.

The characteristics of these 1,394 first admissions with involutional psychoses will be examined in detail in the following sections.

Table 1. First Admissions with Involutional Psychoses to the New York Civil State Hospitals, 1911-1947

Year	Number			Per cent of first admissions			Number per 100,000 of general population		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
1911	38	105	143	1.3	3.9	2.5	0.8	2.3	1.6
1912	33	86	119	1.1	3.1	2.1	0.7	1.9	1.3
1913	51	83	134	1.6	2.9	2.2	1.1	1.8	1.4
1914	61	127	188	1.8	4.3	3.0	1.3	2.7	2.0
1915	43	122	165	1.3	4.1	2.7	0.9	2.5	1.7
1916*	51	113	164	2.0	4.8	3.3	1.4	3.1	2.2
1917	60	141	201	1.7	4.3	2.9	1.2	2.8	2.0
1918	60	159	219	1.7	4.9	3.2	1.2	3.2	2.2
1919	56	205	261	1.6	6.3	3.8	1.1	4.0	2.6
1920	69	174	243	2.1	5.4	3.7	1.3	3.3	2.3
1921	78	184	262	2.1	5.6	3.8	1.5	3.5	2.5
1922	100	176	276	2.6	5.4	3.9	1.9	3.3	2.6
1923	76	159	235	2.1	4.9	3.4	1.4	2.9	2.2
1924	57	174	231	1.5	5.4	3.3	1.0	3.2	2.1
1925	64	163	227	1.7	4.6	3.1	1.2	2.9	2.0
1926	67	156	223	1.7	4.7	3.1	1.2	2.8	2.0
1927	70	170	240	1.6	4.8	3.0	1.2	2.9	2.1
1928	79	179	258	1.7	4.6	3.0	1.3	3.0	2.2
1929	73	170	243	1.5	4.4	2.8	1.2	2.8	2.0
1930	84	151	235	1.7	3.7	2.6	1.3	2.4	1.9
1931	93	177	270	1.8	4.2	2.9	1.5	2.8	2.1
1932	107	184	291	1.9	4.0	2.9	1.7	2.9	2.3
1933	128	203	331	2.1	4.1	3.0	2.0	3.2	2.6
1934	106	189	295	1.7	3.7	2.6	1.6	2.9	2.3
1935	119	296	415	1.9	5.4	3.6	1.8	4.5	3.2
1936	117	348	465	1.8	6.2	3.9	1.8	5.3	3.5
1937	164	379	543	2.4	6.6	4.3	2.5	5.7	4.1
1938	174	523	697	2.6	8.8	5.5	2.6	7.8	5.2
1939	212	535	747	3.1	8.7	5.7	3.2	8.0	5.6
1940	242	596	838	3.5	9.7	6.4	3.6	8.8	6.2
1941	224	570	794	3.2	8.8	5.9	3.3	8.3	5.9
1942	170	627	797	2.4	9.4	5.8	2.5	9.1	5.8
1943*	137	386	523	2.8	8.2	5.4	2.7	7.4	5.1
1944	193	643	836	3.2	9.3	6.4	2.8	9.2	6.0
1945	197	581	778	3.4	8.8	6.3	2.9	8.2	5.6
1946	256	617	873	4.3	9.1	6.8	3.7	8.7	6.2
1947	306	635	941	4.7	9.1	7.0	4.4	8.9	6.7

*First admissions were for 9 months, due to change in fiscal year; rates estimated for 12 months.

Age

The average age of the first admissions with involutional psychoses in 1946-1947 was 53.3 years. Males and females had averages of 55.6 and 52.2 years, respectively. The males are significantly older, in a statistical sense, by 3.4 years. Table 2 shows

Table 2. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Fiscal Year Ended March 31, 1947

Age (years)	Number			Per cent		
	Males	Females	Total	Males	Females	Total
30-34	..	1	1	..	0.1	0.1
35-39	..	23	23	..	2.4	1.6
40-44	14	125	139	3.2	13.0	10.0
45-49	72	228	300	16.6	23.7	21.5
50-54	122	273	395	28.2	28.4	28.3
55-59	116	182	298	26.8	18.9	21.4
60-64	79	89	168	18.2	9.3	12.1
65-69	25	33	58	5.8	3.4	4.2
70-74	4	5	9	0.9	0.5	0.6
75-79	..	2	2	..	0.2	0.1
80-84	1	..	1	0.2	..	0.1
Total	433	961	1,394	100.0	100.0	100.0
Average age (years)	55.6±0.21		52.2±0.15		53.3±0.13	
Standard deviation (years)	6.4±0.14		7.1±0.11		7.1±0.09	

that there are very few admissions under 40 years of age with these disorders. In the case of the males, the majority are concentrated between 50 and 59 years, this interval including 238 cases, or 55.0 per cent. There is a wider age-spread among the females, from about 45 to 59 years. This interval includes 683 cases, or 71.1 per cent.

Since the age distribution of the general population in 1946-1947 is unknown, we cannot compute rates of first admissions according to age for this period. Such data are available, however, for the three years ended June 30, 1941. During this period there were 2,971 first admissions with involutional psychoses to all public and licensed hospitals for the mentally ill in New York State. This group had an average age of 52.2 years, as compared with an aver-

Table 3. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Age, Fiscal Years 1939 to 1941, Inclusive, and Average Annual Rates Per 100,000 Population

Age (years)	Number			Average annual rate per 100,000 population		
	Males	Females	Total	Males	Females	Total
25-29	..	1	1	..	0.1	*
30-34	..	2	2	..	0.1	0.1
35-39	5	35	40	0.3	2.1	1.2
40-44	81	301	382	5.0	18.9	11.9
45-49	159	590	749	10.6	41.2	25.6
50-54	274	597	871	20.8	48.7	34.2
55-59	209	355	564	20.9	36.9	28.7
60-64	89	146	235	11.4	18.4	15.0
65-69	52	51	103	9.2	8.2	8.7
70-74	8	14	22	2.2	3.3	2.7
75-79	2	..	2	0.6	..	0.3
Total	879	2,092	2,971	4.4	10.3	7.3
Average age (years)	53.9±0.16		51.4±0.10		52.2±0.08	
Standard deviation (years)	6.9±1.11		6.6±0.07		6.8±0.06	

*Less than 0.05.

age age of 53.3 in 1946-1947. The latter is in significant excess by 1.1 years. The male admissions averaged 53.9 years in 1939-1944, as against 55.6 in 1946-1947. The female admissions were similarly older in the latter year. It is also significant that the male admissions in 1939-1941 were older than the females.

In the latter years, the average annual rate of first admissions rose among males from a minimum of 0.3 per 100,000 population at ages 35 to 39 to a maximum of 20.9 at 55 to 59 years. At the older ages the rates tapered off rapidly to 0.6 at ages 75 to 79. Among females the rates rose to a maximum of 48.7 at 50 to 54 years, and then fell to 3.3 at 70 to 74 years. With one exception, the female rates were in excess of those of the males in each group, but the relative disparity decreased with advancing age.

Intelligence

Of the 1,394 first admissions, 1,244, or 89.2 per cent, were of normal intelligence, and 80, or 5.7 per cent, were of subnormal intelligence. The latter included 1 idiot, 1 moron, and 76 persons of bor-

derline intelligence. Two cases were considered subnormal, though the degree of subnormality was not specified. The subnormal group included 9.7 per cent of the male admissions, as compared with 4.0 per cent of the females.

Of all first admissions to the New York civil state hospitals during 1946-1947, 10.5 per cent were classified as of subnormal intelligence. This is significantly higher than the percentage among

Table 4. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Intellectual Status, Fiscal Year Ended March 31, 1947

Intellectual status	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Normal	375	869	1,244	86.6	90.4	89.2
Subnormal	42	38	80	9.7	4.0	5.7
Idiot	..	1	1	..	0.1	0.1
Imbecile	..	..	..	..	..	..
Moron	..	1	1	..	0.1	0.1
Borderline	42	34	76	9.7	3.5	5.4
Unspecified	..	2	2	..	0.2	0.1
Unascertained	16	54	70	3.7	5.6	5.0
Total	433	961	1,394	100.0	100.0	100.0

those with involutional psychoses. There was no difference as compared with manic-depressives (5.7 and 5.8 per cent, respectively). First admissions with dementia præcox, however, had a much higher percentage of subnormals, 11.9. In general, it appears that first admissions with involutional disorders belong to a higher grade of intelligence than the average of all first admissions.

Degree of Education

Of the 1,394 first admissions with involutional disorders, 55, or 3.9 per cent, were illiterate; 12, or 0.9 per cent, could read; and 83, or 6.0 per cent, could read and write. More than half (54.7 per cent) had attended common school. Those with a higher education totaled 409, of whom 300 had been to high school, and 109 to college.

First admissions to the civil state hospitals with manic-depressive psychoses in 1946-1947 included 40.0 per cent with high school

Table 5. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State Classified According to Degree of Education, Fiscal Year Ended March 31, 1947

Degree of education	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Illiterate	15	40	55	3.4	4.2	3.9
Reads	1	11	12	0.2	1.1	0.9
Reads and writes	27	56	83	6.2	5.8	6.0
Common school	249	514	763	57.5	53.4	54.7
High school	79	221	300	18.2	23.0	21.5
College	37	72	109	8.6	7.5	7.8
Unascertained	25	47	72	5.8	4.9	5.2
Total	433	961	1,394	100.0	100.0	100.0

educations, and 12.6 per cent with college educations, compared with 21.5 and 7.8, respectively, in the involutional group. First admissions with dementia præcox also exceeded the involutional group in this respect, especially in connection with the percentage receiving high school education. These differences are due in part to the fact that the involutional group is older and therefore belongs to a generation in which educational requirements were less rigorous.

Of the general male population of New York State aged 40 and over on April 1, 1940, 8.1 per cent had no education, 62.5 per cent, had attended grade school, 18.3 per cent, had attended high school, and 8.1 per cent had some degree of college education.[1] Assuming that the patients classified as "illiterate," "reads only" and "reads and writes," correspond to the census group of without education, then the corresponding percentages among male first admissions with involutional psychoses were 10.0, 57.5, 18,2, and 8.6. This indicates a close agreement in educational levels between the involutional group and the general population.

Among females, the percentages of the general population aged 40 and over, with the several degrees of education, were: none, 8.7; grade school, 60.3; high school, 22.2; college, 6.0.[1] Among the female first admissions with involutional psychoses, the corresponding percentages were: 11.1, 53.4, 23.0, and 7.5. This indicates a slight excess among the patients of those with no education, and a

corresponding deficiency of those with grade school education. On the whole, however, there does not appear to be a serious divergence, and therefore we must conclude that first admissions with involutional psychoses appear to be drawn at random from the general population with respect to educational attainments.

Personality Make-Up

Patients admitted to hospitals for mental disease in New York State are described in accordance with their dominant personality characteristics. The characteristics are listed in Table 6. Although they are not mutually exclusive, the patients have been described in accordance with the characteristic which is deemed to dominate the others.

Table 6. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State Classified According to Personality Make-up, Fiscal Year Ended March 31, 1947

Personality make-up	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Schizoid	44	121	165	10.2	12.6	11.8
Cycloid	15	28	43	3.4	2.9	3.1
Paranoid	66	204	270	15.2	21.2	19.4
Epileptoid	1	1	2	0.2	0.1	0.1
Hysteroid	..	4	4	..	0.4	0.3
Neurasthenoid-hypochondriacal	11	14	25	2.5	1.4	1.8
Anxiety character	50	132	182	11.5	13.7	13.1
Compulsive-obsessional	10	12	22	2.3	1.3	1.6
Psychopathic	5	1	6	1.2	0.1	0.4
Unstable	39	61	100	9.0	6.3	7.2
Apparently normal	135	297	432	31.2	30.9	31.0
Unascertained	57	86	143	13.2	9.0	10.3
Total	433	961	1,394	100.0	100.0	100.0

Of the 1,394 first admissions, 432, or 31.0 per cent, were apparently normal. Those with a paranoid make-up totaled 270, or 19.4 per cent. A total of 182, or 13.1 per cent, showed anxiety characteristics. Those with a schizoid make-up totaled 165, or 11.8 per cent. The unstable group included 100, or 7.2 per cent. Compared to all first admissions to the New York civil state hospitals, the involutional group showed significantly higher percentages

with paranoid and anxiety characteristics. They differ significantly from the manic-depressives, who were described largely as cycloid or unstable, and from the cases of dementia præcox, who were primarily schizoid.

Economic Status

Of the 1,394 first admissions, 148, or 10.6 per cent, were dependent; 700, or 50.2 per cent, marginal; and 523, or 37.5 per cent, comfortable. It is impossible to compute rates of first admissions, because of the absence of a comparable classification of the general population.

Table 7. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to economic status, Fiscal Year Ended March 31, 1947

Economic status	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Dependent	34	114	148	7.9	11.9	10.6
Marginal	238	462	700	55.0	48.1	50.2
Comfortable	156	367	523	36.0	38.2	37.5
Unascertained	5	18	23	1.2	1.9	1.7
Total	433	961	1,394	100.0	100.0	100.0

It is evident, however, that as a group, those with involutional psychoses belong to a higher category than the average patient population. In particular, 37.5 per cent of the former were in comfortable economic circumstances, as compared with only 12.4 per cent of alcoholic first admissions, and 14.0 per cent of general paretics.

Marital Status

Of the 1,394 first admissions with involutional psychoses, 214, or 15.4 per cent, were single; 866, or 62.1 per cent, married; 205, or 14.7 per cent, widowed; 67, or 4.8 per cent, separated; and 42, or 3.0 per cent, divorced. The unmarried constituted a relatively larger group among males than females. The widowed were much more prevalent among the females.

According to the federal census of April 1, 1940, 12.9 per cent of the general male population of New York State aged 40 or over were single; 72.3 per cent were married; 8.7 per cent, widowed; 5.3

per cent, separated; and 0.8 per cent, divorced.[2] Of the male patients, 20.1 per cent were single, and they therefore exceeded their quota by 56 per cent. The married, on the other hand, were slightly below their quota, as were the widowed and separated. The divorced group, on the other hand, exceeded its quota by 100 per cent, but in view of the small number involved this cannot be considered significant.

Table 8. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Marital Status, Fiscal Year Ended March 31, 1947

Marital status	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Single	87	127	214	20.1	13.2	15.4
Married	293	573	866	67.7	59.6	62.1
Widowed	29	176	205	6.7	18.3	14.7
Separated	17	50	67	3.9	5.2	4.8
Divorced	7	35	42	1.6	3.6	3.0
Total	433	961	1,394	100.0	100.0	100.0

The marital status of the general female population of New York State, aged 40 or over, on April 1, 1940 was as follows: single, 11.8 per cent; married, 59.1 per cent; widowed, 23.4 per cent; separated, 4.6 per cent; divorced, 1.1 per cent.[2] The single female first admissions with involutional disorders exceeded their quota by 12 per cent. The married met their quota almost exactly, whereas the widows had only 78 per cent of their quota. The separated group exceeded their quota by 13 per cent. The excess among the divorced amounted to 227 per cent.

The preceding data appear to indicate that involutional psychoses are more prevalent among the unmarried than the married, and that they are especially prevalent among the divorced. The data with respect to the widowed cannot be taken at face value. It is probable that the widowed patients are older than the others, and therefore more subject to senile and arteriosclerotic than to involutional disorders.

Environment

Of the 1,394 first admissions, 1,247, or 89.4 per cent, were from an urban environment, and 147, or 10.6 per cent, were from a rural environment. Of the latter, 35 were from the farm population, and 112 from the non-farm population. Of the general population of New York State aged 40 or over on April 1, 1940, 82.0 per cent, were urban, and 18.0 per cent were rural.[3] Thus the rural popula-

Table 9. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Environment, Fiscal Year Ended March 31, 1947

Environment	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Urban	380	867	1,247	87.8	90.2	89.4
New York City	255	615	870	58.9	64.0	62.4
Buffalo	23	30	53	5.3	3.1	3.8
Rochester	8	28	36	1.8	2.9	2.6
Syracuse	9	7	16	2.1	0.7	1.1
100,000-200,000	10	23	33	2.3	2.4	2.4
25,000- 99,999	22	52	74	5.1	5.4	5.3
10,000- 24,999	16	51	67	3.7	5.3	4.8
2,500- 9,999	22	39	61	5.1	4.1	4.4
Out of state	15	22	37	3.4	2.2	2.7
Rural	53	94	147	12.2	9.8	10.6
Farm	18	17	35	4.2	1.8	2.5
Non-farm	35	77	112	8.1	8.0	8.0
Total	433	961	1,394	100.0	100.0	100.0

tion contributed only 58.6 per cent of its quota, whereas the urban population exceeded its quota by 9 per cent. The farm population contributed 20 per cent of its quota. The non-farm population on the other hand exceeded its quota by 35 per cent. Thus, the low rural rate was due entirely to the farm population, whereas the non-farm rural population had a rate in excess of that of the urban population.

The excess of first admissions with involutional psychoses from urban areas resulted from a large excess in New York City. The latter included 53.6 per cent of the population of the state aged 40 and over, but 62.4 per cent of the first admissions, an excess of 16 per cent. The other urban groups admitted slightly less than their quotas.

Use of Alcohol

Of the 1,394 first admissions, 833, or 59.8 per cent, were abstinent; 447, or 32.1 per cent, were moderate; and 73, or 5.2 per cent, were intemperate. The percentage of intemperate drinkers

Table 10. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Use of Alcohol, Fiscal Year Ended March 31, 1947

	Number			Per cent		
	Males	Females	Total	Males	Females	Total
Abstinent	179	654	833	41.3	68.1	59.8
Moderate	187	260	447	43.2	27.1	32.1
Intemperate	49	24	73	11.3	2.5	5.2
Unascertained	18	23	41	4.2	2.4	2.9
Total	433	961	1,394	100.0	100.0	100.0

is much less than that for all first admissions. It is less than that found among manic-depressives and dementia præcox cases.

There is a marked sex difference among first admissions with involutional psychoses with respect to the use of alcohol, with 11.3 per cent of the males intemperate, as compared with 2.5 per cent of the females.

Race and Nativity

Of the 1,394 first admissions, 1,361, or 97.6 per cent, were white, and 30, or 2.2 per cent, were negro. One was an American Indian, and 2 were Chinese. Of the general male population of New York State, aged 40 or over on April 1, 1940, 96.5 per cent were white, and 3.3 per cent were negro.[4] Thus the white population contributed slightly in excess of its quota, the negro population slightly less, but the difference is very slight, and probably not significant. The data for the other races are too few.

Of the white first admissions, 722, or 53.0 per cent, were native, and 638, or 46.9 cent, were foreign-born. Of the state's white population aged 40 or over on April 1, 1940, 57.4 per cent were native, and 42.5 per cent, were foreign-born.[5] Therefore, the native whites contributed only 92 per cent of their quota, whereas the foreign whites exceeded their quota by 10 per cent.

Table 11. First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Race and Nativity, Fiscal Year Ended March 31, 1947

	Number			Per cent		
	Males	Females	Total	Males	Females	Total
White	430	931	1,361	99.3	96.9	97.6
Native	229	493	722	52.9	51.3	51.8
Foreign-born	200	438	638	46.2	45.6	45.8
Unascertained	1	..	1	0.2	..	0.1
Negro	2	28	30	0.4	2.9	2.2
American Indian	1	..	1	0.2	..	0.1
Chinese	..	2	2	..	0.2	0.1
Total	433	961	1,394	100.0	100.0	100.0

Table 12. Foreign-born First Admissions with Involutional Psychoses to All State and Licensed Hospitals for Mental Disease in New York State, Classified According to Nativity, Fiscal Year Ended March 31, 1947

	Number			Per cent		
Nativity	Males	Females	Total	Males	Females	Total
Austria	10	40	50	5.0	9.0	7.7
Canada	2	8	10	1.0	1.8	1.5
China	..	2	2	..	0.4	0.3
Czechoslovakia	3	8	11	1.5	1.8	1.7
England	7	7	14	3.5	1.6	2.2
Finland	2	7	9	1.0	1.6	1.4
France	2	4	6	1.0	0.9	0.9
Germany	14	36	50	6.9	8.1	7.7
Greece	5	6	11	2.4	1.3	1.7
Hungary	2	15	17	1.0	3.4	2.6
Ireland	12	32	44	5.9	7.2	6.8
Italy	49	68	117	24.3	15.3	18.1
Lithuania	2	5	7	1.0	1.1	1.1
Norway	..	8	8	..	1.8	1.2
Poland	29	68	97	14.4	15.3	15.0
Roumania	2	6	8	1.0	1.3	1.2
Russia	44	86	130	21.8	19.3	20.1
Scotland	2	9	11	1.0	2.0	1.7
Spain	2	3	5	1.0	0.7	0.8
Sweden	1	4	5	0.4	0.9	0.8
Switzerland	..	5	5	..	1.1	0.8
Turkey	5	2	7	2.7	0.4	1.1
West Indies	1	7	8	0.4	1.6	1.2
All other foreign countries	6	9	15	3.0	2.0	2.3
Total	202	445	647	100.0	100.0	100.0

Table 12 gives data with respect to the nativity of the 647 foreign-born first admissions with involutional psychoses. Of this total, 130, or 20.1 per cent, were born in Russia; 117, or 18.1 per cent, in Italy; 97, or 15.0 per cent, in Poland; 50 each, in Austria and Germany, or 7.7 per cent; and 44, or 6.8 per cent, in Ireland. Of the foreign-born population in New York State on April 1, 1940, 15.3 per cent were born in Russia. Therefore this group exceeded its quota with respect to first admissions with involutional disorders. The Polish group was also in excess, since it represented only 9.9 per cent of the foreign population as against 15.0 per cent of the first admissions. On the other hand, those born in Germany, Ireland and Italy represented slightly less than their quotas.[6] In view of the absence of an age classification of the foreign-born groups, it is not possible to state whether these differences are statistically valid.

Summary

1. There has been an upward trend in the prevalence of first admissions with involutional psychoses, especially since 1930. This group is now exceeded in frequency of admissions only by first admissions with dementia præcox, psychoses with cerebral arteriosclerosis, and senile psychoses.

2. The involutional psychoses are at their maximum prevalence in the fifth and sixth decades of life. The average age at first admission with these disorders is higher among males than females.

3. The relative rates of first admission are higher among females than males in ratios of from 2 or 3 to 1.

4. The involutional group has a relatively low percentage with subnormal intelligence.

5. The involutional group has the same distribution of educational levels as the general population. It has low percentages with high school or college education as compared with first admissions with manic-depressive psychoses, or dementia præcox.

6. The involutional group showed high percentages with paranoid characteristics and anxiety traits.

7. First admissions with involutional psychoses seem to come from higher economic levels than the general average of first admissions.

8. The involutional disorders appear to be more prevalent among the unmarried than among the married.

9. The rural population had a lower rate of first admissions with involutional psychoses than the urban population. This was due to a very low rate among the farm population.

10. The percentage of intemperate drinkers was low among the involutional group.

11. Negroes contributed slightly less than their quota with involutional psychoses, whites slightly more than their quota, but the difference is not significant.

12. Foreign whites had a higher rate than native whites, and foreign whites born in Russia and Poland had rates in excess of their quotas. However, such rates cannot be compared directly in view of the absence of necessary data with respect to age distributions.

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Department of Mental Hygiene
Governor Alfred E. Smith State Office Building
Albany 1, N. Y.

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2. Ibid. Pages 23 and 38.
3. Ibid. Page 5, 25-32.
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5. Ibid. Page 13.
6. Ibid. Page 26.

REVIEW OF LEGISLATION OF THE YEAR 1948

BY KARL E. WASMUTH AND PAUL O. KOMORA

More than the usual plethora of bills confronted the New York State Legislature during its 1948 session. Altogether 5,535, the greatest number in years, were considered: 2,560 by the senate and 2,975 by the assembly, compared with a total of 5,313 introduced in 1947. However, only 1,111 reached the governor, fewer than at the end of the 1947 session. Incidentally, this year's session, which lasted 67 days, was the shortest since 1932. The governor approved 876 bills; 235 were vetoed.

Of the 10 bills introduced at the request of the Department of Mental Hygiene, eight were signed and two failed of passage. These, as well as other measures affecting the department, are listed below and described. The grouping is the one used in previous annual legislative reviews: "appropriations," "mental hygiene," "medical and nursing practice," "correctional and penal," "civil service," and "miscellaneous." Except where otherwise indicated, the new laws or amendments went into effect immediately upon approval by the governor.

Appropriations

Under Chapters 1, 100, 102 and 468 of the Laws of 1948, sums were appropriated to the Department of Mental Hygiene aggregating over $100,000,000 for operating expenses during the fiscal year 1948-49, the largest amount ever earmarked for the department for one budget year.

Appropriations for personal service total $59,061,761, including $3,000,000 for new positions. The increase over personal service appropriations for last year is approximately $21,000,000. This does not include the cost of emergency compensation (cost-of-living increases) which is appropriated in a lump sum for all state departments.

Appropriations for maintenance and operation are $28,655,019, which represents an increase of $6,560,930 over last year. In addition, $600,000 was appropriated for the new Willowbrook State School, and $100,000 for special research.

New appropriations for capital projects from postwar funds amount to $5,306,400, plus $1,093,000 for rehabilitation and improvements. Allocations of about $1,585,000 for equipment items are also expected from a lump sum appropriation made for all state departments. The usual amount of $669,783 is appropriated to the State Hospital Retirement Fund. Included in the grand total of appropriations is $4,565,850 for deficiencies in maintenance and operations and $75,000 for deficiencies in personal service for 1947-48.

Mental Hygiene

Chapter 624 amends the New York City administrative code to extend to April 7, 1949, the date when patients in Manhattan State Hospital must be removed from buildings on that part of Ward's Island which is to be developed into a public park.

Chapter 609 appropriates $35,000 to the Department of Mental Hygiene for a study at Sing Sing of offenders convicted of sex crimes, and directs the commissioner of correction to transfer prisoners from other correctional institutions to Sing Sing for this purpose.

Chapter 792 adds a new section, 53, to the mental hygiene law to authorize peace officers to apprehend patients who have escaped from mental institutions.

Chapter 33, effective July 1, 1948, amends section 44 of the mental hygiene law to make clear that, without permission of the Supreme Court, no civil action can be brought against a deputy commissioner, an officer or employee of the Department of Mental Hygiene or a member of a board of visitors for alleged damages because of any act performed or because of failure to perform any act while discharging official duties.

Chapter 32, effective July 1, 1948, amends section 201 of the mental hygiene law (relating to inebriates) to require the filing of sealed admission papers with the county clerk.

Chapter 362, effective July 1, 1948, amends section 7 of the domestic relations law to provide that in an action for annulment of marriage on the grounds of insanity, the court may accept the testimony of a state hospital physician taken by deposition before a referee or may require him to testify in court.

Chapter 310 authorizes the Commissioner of Mental Hygiene to exchange certain lands which are part of Willard State Hospital's grounds for other lands in the vicinity.

Chapter 350 amends the public officers law to make it possible for institution directors to allow equivalent time off to employees (veterans) in lieu of Memorial Day and Armistice Day.

Chapter 47, effective July 1, 1948, amends sections 75, 77, 82 and 87 of the mental hygiene law by making certain changes and corrections in language.

Chapter 734 adds a new section, 206, to the mental hygiene law, effective July 1, 1948, to provide that a child born to a patient in a state mental hygiene institution may be placed by the director in the care of the commissioner of public welfare of the county from which the patient is admitted.

"Program" Bills Lost

The following bills, sponsored by the department, failed of passage:

Senate Int. 1257, Print 1309 would have amended section 87 of the mental hygiene law to provide that when the expenses of patients on convalescence from a state mental hospital are the liability of a public welfare official of the town, city or county in which the hospital is located, such official would be authorized to charge maintenance costs back to the public welfare official of the place in which the patient was domiciled at the time of admission.

Senate Int. 858, Print 879 would have amended sections 73 and 123 of the mental hygiene law for the purpose of clarifying certain provisions relating to admissions on the certificate of one physician in the case of the mentally ill, and of one physician or one psychologist in the case of the mentally deficient.

Bill Opposed and Vetoed

Senate Int. 926, Print 2947 would have added a new section, 74a, to the mental hygiene law to permit patients in "temporary custody" to communicate with relatives or friends, a privilege already available under present regulations.

Bill Opposed and Failed to Pass

Assembly Int. 682, Print 687 would have made it mandatory instead of permissive that mental hygiene institutions receive funds or property (except jewelry) valued up to $500, belonging to a patient who has no committee if he is under care for more than three months.

Medical and Nursing Practice

Chapter 438 amends section 6512 of the education law to suspend, until July 1, 1949, the provision that interns and medical students in hospitals shall have certain educational qualifications.

Chapter 439 amends section 6905 of the educational law to authorize the state education department to license, without examination, graduates of schools of nursing accredited in other states to practise, under certain conditions, as registered professional nurses, in this state.

Chapter 385 amends section 6906 of the education law to permit the licensing, under certain conditions, as practical nurses of persons who have been lawfully engaged in the practice of nursing in the state for one year, or who have practised elsewhere for one year and who have been residents of the state for one year prior to July 1, 1948.

Chapter 195 amends section 6905 of the education law to postpone until April 1, 1949 enforcement of the provision in the nurses practice act that no one other than registered professional nurses or licensed practical nurses may practise nursing for hire in New York State.

Chapter 194 amends section 6907 of the education law to authorize the state education department to license without examination a practical nurse licensed in another state or country, and to admit a graduate of a school for practical nursing in another state or country to a licensing examination in New York State.

Correctional and Penal

Chapter 377 amends section 384 of the correction law, effective July 1, 1948, to require the head of Dannemora State Hospital for the criminal insane to initiate action within 30 days prior to the expiration of a prisoner's sentence to recommit the prisoner to

that institution on a civil order if found insane, according to the procedure prescribed in section 408 relating to commitments to Matteawan.

Chapter 447 amends section 408 of the correction law to require the transfer of a prisoner to Bellevue or Kings County Hospital for observation if the physician of a penal institution in New York City reports that the prisoner is insane.

Chapter 433 amends section 662e of the code of criminal procedure to increase from $10 to $25 the fee paid in up-state counties to a psychiatrist designated to examine a defendant in a criminal action.

Civil Service

Chapter 239 continues the merit award board (established in the civil service department in 1946 and renewed in 1947) on a permanent basis.

Chapter 139 grants to state employees receiving less than $11,000 a year certain emergency salary increases, not to exceed $900 a year, beginning April 1, 1948, on a graduated scale.

Chapter 596 amends section 42 of the civil service law, effective April 1, 1948, by eliminating the provision for additional compensation for more hazardous or arduous duties than those normally performed by an employee.

Chapter 272 extends to April 1, 1949 the provision in the civil service law that an employee continuously employed under a provisional or temporary appointment, is entitled, upon permanent appointment, to salary credit for such temporary service.

Chapter 742 amends section 50 of the civil service law, effective July 1, 1948, to extend from 90 days to one year the permissible time for the reinstatement of veterans following discharge from military service, and liberalizes the definition of eligibility for membership in the retirement system in respect to military service.

Chapter 43 amends the civil service law by restating and clarifying the provisions of section 16 relating to the promotion, transfer and reinstatement of civil service employees.

Chapter 70 amends the civil service law by restating and clarifying the provisions of section 14 relating to applications, examinations and eligible lists for competitive class positions.

Chapter 670 amends section 200 of the election law, which requires that employees be allowed leave of absence for two successive hours for voting purposes, by specifying that all employees of "the state and all of the civil divisions thereof including cities and villages" are included in this provision.

Chapter 201 amends section 43 of the military law by redefining the term "ordered military duty" to cover orders issued with the consent of the individual.

Chapter 503 revises generally the provisions relating to the state employees' retirement system. Particularly it provides for optional retirement of state police after 20 years of service and provides for service credit for members of the system who served in World War II.

Senate Int. 2259, Print 2504 proposed an amendment to section 6 of article V of the constitution to extend the present preference of non-disabled veterans in appointments to the civil service from December 31, 1950 to December 31, 1955.

Senate Int. 2370, Print 2615 proposed an amendment to section 6 of article V of the constitution to repeal by December 31, 1950 the absolute preference in competitive civil service examinations now given disabled veterans and the secondary preference given non-disabled veterans, and substitute a system of credits for disabled and non-disabled veterans in civil service examinations.

Miscellaneous

Chapter 173 amends section 8 of the state finance law to provide indemnity to employees, not exceeding $150, for damage to personal property caused by fire in institutions of the Departments of Mental Hygiene, Health, Correction, and Social Welfare.

Chapter 179 adds a new section, 331a, to the public health law to require that vaccines used for immunizing persons against tuberculosis must be produced according to regulations of the State Health Department.

Chapter 9 suspends until July 1, 1949 the prohibition against the use of butter substitutes by public and private institutions receiving public funds.

Chapter 112 continues the Joint Hospital Survey and Planning Commission until April 1, 1949 and provides that federal funds received by the commission shall be disbursed only pursuant to a resolution adopted by a majority of the members of the commission.

A resolution introduced by Senator Desmond and adopted by the senate and the assembly continues the committee created in 1947 to study problems of the aged, and appropriates $25,000.

A resolution introduced by Assemblyman Schulman and adopted by the senate and the assembly continues the committee created in 1946 to study cerebral palsy, and appropriates $30,000.

Department of Mental Hygiene
Governor Alfred E. Smith State Office Building
Albany 1, N. Y.

FORBIDDEN FRUIT

BY JAMES A BRUSSEL, M. D.

That old trooper, ego,
  Would never have battled
The grim super-ego,
  Resulting in rattled
Cerebral disaster,
  Torn, wounded, and bleedin',
If Eve, damn and blast 'er,
  Shunned apples in Eden.

Reality dangers
  And unconscious wishes
Would live, not as strangers,
  But find life delicious;
The sexual mix-up
  Which all peoples breed in
Were barred from a fix-up
  By apples in Eden.

The chronic organic,
  The psychoneurotic,
Depressive and manic,
  The overt psychotic,
Defective, demented,
  From Shanghai to Sweden,
Were never prevented
  With apples in Eden.

EDITORIAL COMMENT

NO STEP-SIBLING—PSYCHOLOGY!

We sometimes wonder if, among the unrecognized specialists in the general field of mental illness, we should not place the clinical psychologist with the foremost. For long, psychology with its roots in philosophy and education, and psychiatry with its base in empiric medicine pursued courses as separate as if each were sealed in its own inviolate compartment under the dread invocation of Hermes Trismegistus. Of later years, it has been evident that, however diverse their origins and pathways, the two disciplines have been proceeding toward the same goal. A Viennese neurologist investigates functional disorder and develops a new school of psychiatric therapy; many psychologists develop from his views what they consider basic principles of "psychology." A psychologist writes a text on "abnormal psychology"; psychiatrists use it in medical schools as perfectly good "psychiatry." A psychiatrist designs a "projective" personality test; it is now in wide use by psychologists.

One cannot say, nevertheless, that psychiatry and psychology are identical or approaching identity—or even that each has yet learned to make the most of the other's potentialities. They may share a scientific field, but their approaches, methods and aims are widely different, so much so that misunderstanding and misapprehension are very common. As extremes of such misunderstanding, one might cite the psychiatrist who admits grudgingly that the psychologist possibly is of some use in measuring mental defect in institutions for aments but who thinks psychology has nothing to contribute where mental derangement is concerned. Or one might cite the psychologist who believes that medical men are wasting their time attempting to treat psychotics—who are victims of congenital and irremediable inferiority and who ought to be turned over, for custodial care only, to the wardenship of the psychologists. One may not accept these actual if somewhat fantastic opinions as representative, but may still recognize that psychology, particularly social and industrial psychology, could well make in-

creased use of psychiatry, and that psychiatry needs the increasing co-operation of psychology, specifically of clinical psychology.

Psychiatry is making an initial concrete step toward such co-operation today, with the establishment in public mental hospitals and other psychiatric services throughout the country of staff positions for psychologists in unprecedented numbers. The war demonstrated not only that psychiatrist and psychologist could work as a team but that they made an uncommonly good team. It is now the task of psychiatry, of institutional psychiatry in particular, to extend the benefits of wartime co-operation to the problems which psychiatry and psychology share in civil life.

It would be highly desirable, of course, if every psychiatrist could also be thoroughly trained in the methodology and the use of the tools of clinical psychology. But it might require the three hundred sixty and five years of the days of Enoch, if not the nine hundred sixty and nine of the days of Methuselah, to acquire all the knowledge and skills which the psychiatrist might find desirable. The field of psychiatry has become infinitely complex since the days when Amariah Brigham headed a small and primitive institution and was expected himself to embody all the medical and allied skills involved in treatment and administration. The psychiatrist has long since found that he cannot also be an internist, a laboratory director, an occupational therapist, a physiotherapist, a pharmacist, a nurse and a social worker. But he has, perforce, and using inadequate tools, often attempted work which can be better done by the clinical psychologist.

Generally recognized requirements for specialization in psychiatry today are an academic university education, graduation from an approved medical school, general internship and at least five years of psychiatric practice under conditions amounting to apprenticeship. A diploma from the American Board of Psychiatry and Neurology calls for intensive study and the passing of a rigorous examination. Besides this, the psychiatrist is likely to have done some research, to have studied neurology and, perhaps, psychoanalysis.

It is little wonder then that few psychiatrists except those specializing in research have found the time to become proficient also in clinical psychology, a profession which requires its own two to

three years of university graduate study followed by internship and practice under conditions resembling those accorded the young psychiatrist. It is not remarkable that, under this circumstance, psychiatry is now welcoming into its field co-workers who promise to be the most valuable aides the profession ever had, and about whose capacities and potentialities few psychiatrists have adequate knowledge.

Since the psychologists are coming by invitation into the psychiatric field, not the psychiatrists into the psychological, the primary responsibility for orientation, and for making the fullest use of the important new clinical instrument which psychology brings, rests on psychiatric practitioners and administrators. The psychologist, of course, will not be well advised to hide his light behind a blackout of diffidence; he is coming to practise his profession among fellow-workers who not only do not know what he can do but who may not even understand much of his language. It is reasonable to expect and to invite him to make his potentialities known; but it is of even greater importance that those who supervise and work with the clinical psychologist find out for themselves what those potentialities are and then see that they are employed to the greatest advantage.

Today's psychiatrist does not roll his own pills, mix his own elixirs or design his stethoscope or sphygmomanometer. He does not conduct his own laboratory tests. Unless he has had special instruction and experience, he does not pretend to interpret electrocardiograms, electro-encephalograms or pneumo-encephalograms. He obtains his medications and his instruments from experts, sends his laboratory work to other experts and consults still others on difficult technical problems. The clinical psychologist is such an expert.

One may illustrate readily from diagnostic procedure. In earlier years, medical staffs pored over anamneses, considered symptoms, studied ward reports and scrutinized delusional content painstakingly to arrive at a diagnosis of general paresis. Today, blood and spinal fluid specimens go to the laboratory for Wassermann, Kahn or colloidal gold tests; and, in conjunction with certain psychiatric and neurological symptomatology, the question of cerebral syphilis is settled forthwith.

Clinical psychology can perform the same diagnostic service in other conditions—with a similar saving in time and similarly increased accuracy.

The projective method which is probably the best known to psychiatrists, the Rorschach examination, has been developed into a delicate diagnostic instrument for the differentiation of functional derangement from organic brain disorder. The same instrument has proved itself reliable and time-saving in other diagnostic problems, the differentiation, for example, of neurosis from what is sometimes called "larval" schizophrenia—the symptoms of neurosis and incipient schizophrenia may be similar, but differences in the Rorschach patterns of the two conditions are often clear and significant. The value of this procedure in out-patient clinics is self-evident.

The Rorschach has already been of some limited use in our institutions; there are probably many psychiatrists who can recognize Piotrowski's organic signs and form conclusions from them, others who can recognize and interpret Harrower's simplified signs for the neuroses. But to make full use of this method requires months or years of training and practice. The competent clinical psychologist brings to our institutions in general possibilities in the employment of this instrument alone which were hitherto available only in research centers. He also brings other instruments of comparable value in diagnostic matters: the Thematic Apperception Test, the Goodenough Drawing Test, the Wechsler-Bellevue Adult Intelligence Scale, all of which can, in competent hands, save time and avert errors for the psychiatrist.

In prognosis, the psychiatrist may also call on the clinical psychologist. Here too, the projective techniques are important instruments. Much research and experimental work have been done, for example, on the matter of prognosis for shock treatment. Methods are still to be standardized and results are still far from infallible; but the experienced psychologist, nevertheless, can contribute much in helping the psychiatrist to separate for treatment those who are likely to improve and those who are unlikely to do so. In institutions where shock treatment cannot yet be extended to all, the selection of patients most likely to benefit is a matter of vast importance. And by use of the techniques employed in progno-

sis—and with others in addition—the clinical psychologist is often able to assess the results of treatment more quickly and objectively than can be done by the psychiatrist.

Much current knowledge and current theory regarding the mode of operation and the results of shock treatment come, not from psychiatric observation, but from long and painstaking work in our psychological laboratories. Intensive research in widely scattered laboratories all over the country now promises comparable conclusions as to the processes and results of pre-frontal lobotomy and topectomy.

The psychiatrist will find the psychologist indispensable in the administration of intelligence and other tests often necessary to distinguish between mental deficiency and mental disorder; and it seems likely that this procedure will become routine with children.

Social service will find the psychologist of great help in determining the mental and vocational possibilities of convalescent patients and in assisting with the problems of family adjustment, occupation and social relations which are the responsibilities of the after-care clinics.

In all phases of his mental hospital work, the clinical psychologist can bring a collection of precision tools and exact techniques where the psychiatrist has had few instruments and little time for exactitude. The psychiatrist may check his clinical impression of deterioration by the Shipley-Hartford Deterioration Scale. The psychologist, however, can check the Shipley-Hartford results against the Wechsler-Bellevue test; he may supplement his Rorschach conclusions with the Graphic Rorschach technique; he will at the least have at his disposal a battery of half a dozen basic tests and numerous supplementary ones which cannot be employed readily by others.

Finally, the clinical psychologist comes to the mental institutions with a good theoretical—sometimes better than theoretical—knowledge of psychiatry. Trained in principles developed at such research centers as Bellevue Hospital and the New York State Psychiatric Institute, the clinical psychologist is more than an accomplished technician; he not only knows what he is doing but what he is doing it for. He is able to impart and interpret his findings understandingly. How far his knowledge should be drawn upon

for assistance in, or conduct of, psychotherapy, is a subject of bitter controversy and need not concern us too much here. There are comparatively few psychologists either trained or adapted for psychotherapeutic work; in any case, most institutional psychologists will find more than sufficient demands on their time in the practice of their primary specialty. Further than that, competent medical administrators will determine the tasks in which their new personnel will be best occupied. Aside from the Veterans Administration, where psychologists are conducting much group psychotherapy, the question of whether the institution psychologist should practise psychotherapy as well as psychology is likely to remain academic rather than practical for some time to come. He will simply be otherwise occupied.

The research activities, as well as care and treatment, in our institutions, should benefit from the presence of the clinical psychologist. His training includes familiarity with and practice in research work; the clinical psychologist should be able to direct or carry on research projects which have been impracticable under past hospital organization. The psychologist comes to the mental institutions well trained and well equipped for his duties. For the last 10 years in New York State, for example, the Department of Mental Hygiene has conducted intern training programs at Letchworth Village and Rockland State Hospital; this work has now been extended to include hospitals all over the state, and the Department of Social Welfare, the Department of Correction, the State Education Department and the Department of Civil Service are now co-operating in this phase of training. The New York hospitals at least are assured of personnel with background and experience adequate for the tasks to be undertaken.

Those tasks are no light ones. They can be greatly facilitated, the standards of diagnosis and treatment can be significantly improved, and general knowledge of the nature and course of mental disorder can be vastly widened if the medical administrators and their medical colleagues will see that the clinical psychologist's welcome to their hospitals is not only cordial but is based on general acquaintance with and intelligent appreciation of the possibilities he brings with him.

BOOK REVIEWS

Psychosocial Medicine. A Study of the Sick Society. By JAMES L. HALLIDAY, M. D. 278 pages with appendices, subject and author index. Cloth. W. W. Norton & Company, Inc. New York. 1948. Price $3.50.

In the happy event that society lives to assess this book, it may well turn out to be one of the most important of recent years. Not only does it explain the psychosomatic approach to the individual with a most unusual clarity, but it carries that approach further and applies it to "sick society," which certainly needs something applied to it. The fact that this author's "something" is apposite and understandable merely makes it the more amazing. No serious student will be content to let this book go with a single reading. Rather, it will be the subject of study and reflection, reading and re-reading, worthy of a binding to last.

It is impossible to pick any few quotations, or ideas, which could approximate a concept of the magnitude and importance, as well as the thoroughness of this work. It deals with the means of diagnosis of sick society, and offers hope for the future. Perhaps the *Decline of the West* can be slowed. If not, those who read this description of the relevance of the psychosomatic approach to society, as society is at present disintegrating, may have the prospect of watching the disintegration with a very fine copy of the score.

Parris Mitchell of Kings Row. By HENRY and KATHERINE BELLAMANN. 333 pages. Cloth. Simon and Schuster. New York. 1948. Price $3.00.

This novel, which Mrs. Bellamann calls the continuation of *Kings Row*, is, in a sense, like its parent novel, a kaleidoscopic portrait of the inhabitants of that small town with particular emphasis on Dr. Parris Mitchell, the pivotal figure. A young doctor in the days when psychiatry was regarded with open hostility and suspicion, he is indeed a prophet without honor in the locale of his beginnings.

The story treats of his attempts to bring meaning and balance into the lives of a sometimes resentful and inflexible set of individuals; of his efforts to stem inevitable tragedy in the existence of others, while growing in intellectual and emotional stature through these contacts.

Mrs. Bellamann collaborated with her late husband in this work and has attempted to preserve as much of Henry Bellamann's lucid and telling style as possible. The novel makes an interesting study and there is cause to regret that Mr. Bellamann did not live long enough to complete the originally planned trilogy of Kings Row.

Handbook of Psychiatry. By WINFRED OVERHOLSER and WINIFRED RICHMOND. 252 pages. Cloth. J. B. Lippincott Co. Philadelphia. 1947. Price $4.00.

The authors call their book a *Handbook of Psychiatry* and state that it is intended for lay consumption. The title is consequently misleading, as it would direct the layman away from the book as too technical. The authors have covered, briefly, most of the major topics of psychiatry such as description of the neuroses and psychoses, psychoanalysis, the role of psychiatry in education and family relations, psychiatric disorders in children, crime and mental disorders, organic disorders, mental aberrations of war, alcoholism, and the difference between psychology and psychiatry.

The authors state in the very last paragraph of the book, "This book has been written in the faith that the layman wants to know more about psychiatry, and that, rightly informed, he will lose much of his dread of mental abnormalities and be willing, even eager, to join with psychiatry and mental hygiene in advancing the campaign for better human beings in a better world." Despite the fact that the book is well written, clear and easily readable, it is doubtful whether it will accomplish what the authors intend for it.

The White Goddess. By ROBERT GRAVES. 412 pages. Cloth. Creative Age Press. New York. 1948. Price $4.50.

This is an astonishing book to have been written by a poet; but possibly only a poet could have traced its implications, or have had the courage to attempt it.

"The white goddess" is our lady of many titles—Caridwen, Demeter, Astarte, Baalith, Ariadne, Hera, Lilith, the Hag, Hecate, the Lady of the Lake and *La Belle Dame sans Merci*. The White Goddess is the giver of life, the giver of ecstasy and the destroyer, death. From the ancient Welsh myth Câd Goddeu, "The Battle of the Trees," Graves traces the goddess to Crete, Lybia, Asia Minor, Palestine and Egypt. The quest of the Great Mother leads Graves through the long-unsolved medieval riddles of the Câd Goddeu to the mysteries of Eleusis and Samothrace, the formation of the Greek and Celtic alphabets, and decipherment of the Holy Unspeakable Name of God, through the island of Calypso to the bloody Eucharist of the Old Stone Age as shown in Aurignacian cave art. Through this pilgrimage to the ultimate, Graves displays enormous erudition and the fruits of vast research. One hopes that he will some day re-publish his theories and conclusions with the more explicit citations and illustrations necessarily omitted from a book intended for popular reading.

Graves has combined the methods of anthropology and what he would probably call poetic intuition; the psychoanalyst might have another word for it. For what Graves is exploring is no more the history of European culture than it is the development of the unconscious. Graves, for instance, emphasizes the importance of the female trinity, the triple trinity of the nine-fold goddess—very likely to the undue depreciation of the male trinity—but he adds mountains to the already huge volume of evidence, collected by Briffault and others, that the supremacy of the female came before the rule of the male. If this is finally substantiated, it would require modification of the Freudian theory of the primal horde and of the development of guilt and of the Eucharist. It would relate the castration complex to the phallic mother rather than to the father and might necessitate a re-evaluation of all pre-Oedipal factors. One may guess at the importance this thesis holds for the author in that he feels no poetry is genuine unless written under the influence of the White Goddess.

The vast implications which this work may hold for practical psychotherapy, as well as for basic theory, are at this point only to be surmised.

The Driving Forces of Human Nature. By THOMAS VERNER MOORE, O. S. B., M. D. 461 pages. Cloth. Grune and Stratton, Inc. New York. 1948. Price $6.50.

The author states, "This book is an attempt at a synthesis of various currents in modern psychological thought." Dr. Moore discusses the development of philosophy, psychology and psychiatry and shows the relationship of these trends. He outlines a few methods for the treatment of mental conditions and includes a number of excellent case studies.

Part I is a historical introduction to psychology, covering the concept of psychology and the foci of development in American psychology; Part II contains a discussion of the conscious and the unconscious; Part III deals with human emotional life; Part IV is a discussion of various neurotogenic disorders such as gastro-intestinal upsets, cardiac conditions, and psychogenic blindness; Part V covers instincts and impulses, desires, conflicts, psychotaxes and parataxes, the parataxis of anxiety, that of defense, the question of compensation and sublimation; Part VI is a discussion of will and voluntary action; Part VII concerns the problem of volitional adjustment.

Father Moore says, "*The Driving Forces of Human Nature* might well serve as a preparation for one who plans to go on to the study of psychiatry." The reviewer agrees but feels, however, that the book tries to cover too much ground and consequently is not exhaustive enough to accomplish this purpose adequately. Nevertheless, it is well written and certainly worthy of reading.

Diagnostic Psychological Testing. Vols. I and II. By DAVID RAPAPORT. Vol. I, 573 pages, Vol. II, 516 pages. Cloth. Menninger Clinic Monograph Series, No. 3. The Yearbook Publishers, Inc. Chicago. 1945. Price, Vol. I, $6.00; Vol. II, $6.50.

These two volumes have proved to be of great value to the clinical psychologist. In clear language and well organized form, the basic rationale of a battery of psychological tests is presented so that the information on each is readily accessible. There is material for both the beginner and the more advanced clinician, as the study covers aspects from administration and broad, general discussion, through some of the finer points of interpretation.

Dr. Rapaport bases his conclusions on the results of administering the battery to a clinical group of various categories of psychiatric patients at the Menninger Clinic, and a control group of members of the Kansas Highway Patrol. However, the elaborate statistical evaluations based on this research population are often confusing, and the validity sometimes questionable. As the author often extends the discussion beyond the scope of the actual results anyway, a more pointed and condensed statistical presentation would probably make these volumes handier and more effective.

In these days of upcroppings of dozens of psychological tests that soon prove to be of very limited value, the choice for this battery has proved to be fairly good: It is composed of the Wechsler-Bellevue intelligence scale, the Babcock deterioration test, the sorting test, Hanfmann-Kasinin test, the word association test, the Rorschach, the thematic apperception test and the Szondi (the results of the latter not being presented as planned in this book). These are for the most part tests which are in most general use by the clinical psychologist today, especially the Wechsler-Bellevue and the Rorschach. The Szondi will probably be more in demand as the materials are becoming available and the author's work is translated. A limitation which will also probably soon be felt more strongly is lack of discussion of the Goodenough Drawing test which is rapidly becoming a widely used part of the clinician's battery as an easily administered projective test and fruitful source for diagnostic interpretation. However, these volumes are a research study and not basically a clinical manual in purpose and scope. Particular commendation might be made for the extensive survey of the Wechsler-Bellevue Scale and its various subtests, a welcome addition to David Wechsler's *Measurement of Adult Intelligence.*

The author's warnings, as well as his indications of diagnostic "clues," are important contributions. Rather than the enthusiasm and faith in some particular test of some psychologists, he urges a more complete battery and a careful evaluation of every indication noted in diagnostic testing.

The Psychology of Behavior Disorders. A Biosocial Interpretation. By NORMAN CAMERON, M. D., Ph. D. 598 pages. Cloth. Houghton, Mifflin Co. New York. 1947. Price $5.00.

Dr. Cameron, professor of psychiatry at the University of Wisconsin Medical School, is well equipped to write a book of this sort, which attempts to bring psychology and psychiatry into closer relationship. Because he was, for some time, closely associated with Adolf Meyer, Dr. Cameron has developed a system of classification and interpretation of emotional problems similar to that of Meyer.

In his preface, Dr. Cameron is particularly forceful in advising that there should be a break from the antiquated idea of psychosomatic medicine; that we should emphasize "a biological organism operating in and by means of a social environment . . . The biosocial interpretation departs from the traditional psychobiology by dispensing entirely with the concept of consciousness and the distinction between the mental and non-mental. This concept and this distinction are both residues from the once flourishing systems of psychosomatic dualism. We can neglect them in behavior pathology without missing them."

Dr. Cameron re-defines the usual psychological mechanisms and uses his own classification of mental disorders. He believes that we needlessly segregate psychotic from neurotic disorders in the usual way of thinking. He divides them into eight main clinical syndromes. Yet, in the final chapter, "Therapy as Biosocial Behavior," the author does not present any particularly new ideas. The "biosocial interrelationship" is the same as that which the average psychiatrist uses, and the ultimate results are the same.

Psychotherapy in Child Guidance. By GORDON HAMILTON. 322 pages. Cloth. Columbia University Press. New York. 1947. Price $4.00.

In showing how psychoanalytic principles have been adapted at the Jewish Board of Guardians, Gordon Hamilton, in *Psychotherapy in Child Guidance*, has shown the imperative and pressing need for a more workable understanding of psychotherapy in social work. The limitations in the application of such therapy by untrained workers are pointed out and the importance of an integration of education, social, and therapeutic measures is stressed.

Gordon Hamilton's book has helped clear the way for a better understanding of psychotherapy in social work and for a closer and more flexible working relationship by members of this profession with those of the field of psychiatry.

The Outer Edges. By CHARLES JACKSON. 240 pages. Cloth. Rinehart & Co. New York. 1948. Price $2.75.

Jackson's book is the story of the onlookers and kibitzers of murder, and an attempt to answer the "unanswerable question" (p. 215) of what is going on in the minds of fascinated spectators of a sensational murder. Johnson's answer is simple enough: Everyone harbors murderous wishes; the difference between murderer and spectator is "only in kind, in degree." (P. 214.) With this objectionable premise, Jackson tells in a sketchy manner of the dreary fate of Jim Harron, happy-go-lucky public relations director, man of "boyish ebullience," who turns out to be a severe case of sick conscience of unknown origin, since no infantile background is given. What happens to the poor man during *one* single day, "should not happen to your worst enemy": He loses his peace of mind, his wife, his child, his "girl friend." Harron started the day in good humor; he was driving back to New York from a vacation, accompanied by his wife and five-year-old daughter. Everything went well ("to his way of thinking he had everything to make him happy: his child, his wife, and his girl—in that order"); he was only slightly bothered by a "faint pang of conscience" about his extramarital affair concerning which . . . "much as he enjoyed playing the lover, he was unable quite to keep the role of the father out of their relationship."

Then Harron ran over a little girl's dog; he did not stop, drove on, even denied before child and wife that the accident happened. More and more "jumpy" he telephoned to his girl from a gas station and was overheard by his wife, who took the child and left him. Harron sought refuge with the girl, who at that time was sleeping with another man; he was practically thrown out.

For the next few days Harron was preoccupied with a murder which had occurred during his ride home, he had even met the murderer at the road; a "dull-witted" boy of 16 who had slaughtered two children. Plunged into depression, Harron thought a great deal about the dog he killed (little about wife and child). Finally, he visited the father of the murdered children, offering money, only to be severely rebuffed.

The reasons for his depression are not explained by Jackson; the reader is asked to connect the loose ends himself: "girl friend—own daughter—dog belonging to a little girl—once more own daughter. Not too reticent is Jackson in stressing Harron's guilt: Harron reproaches himself for aggressive wishes, considers himself a murderer in thought. With amazing consistency, the real "crime," overdimensional psychic masochism, is omitted. Jackson obviously has no idea that guilt for aggressive thoughts is

accepted by Harron as a "lesser crime," to camouflage the real crime—repressed masochism.

Besides Harron, there are a few other shadowy outlines of people, all emotionally affected by the murder. These are all but marionettes to prove Jackson's point: Murder fascinates because it acts as a catalyst to bring volcanically to the surface repressed aggression in the spectator. These other *dramatis personae* are barely sketched: One has the impression that the author outlined his book, and did not, or could not, fill in the chapters.

The same sketchy and sloppy job is done with the murderer himself. The "moronic" boy is not even granted a psychology of his own. His state of mind before the murder is described by psychologist Jackson: ". . . vague feeling that something was about to happen to him before the day was over that would make him very important. From the rear pocket of his jumper he drew out the hedge-clippers and admired the shiny blades. He felt ready for anything. It was like the famous night last winter when his parents' house had been destroyed by fire and his mother burned alive. In his almost 17 years he had never known such excitement . . . Feelings of power stirred in him. He felt absolutely wonderful. . ." This caricature of a motivation for murder—obviously one gets nowadays absolution from motivations if the word "mother" is only mentioned—is dismissed by Jackson for two reasons. First, he is not interested in the murderer, he needs him only as a prerequisite to study the reactions of spectators; second, the boy is moronic anyway, why bother? Without having the slightest awareness of what he is talking about, Jackson identifies schizophrenia with—stupidity. Quite a diagnosis!

Jackson's opinions on criminology are outdated and can be traced precisely to Stekel's misconceptions uttered 40 years ago; Stekel endowed every child with "universal criminality." Someone ought to bring Jackson up to date in psychoanalytic-criminologic studies. Later studies (Bergler, Schilder-Keiser, Alexander-Healy) consider the criminal act as an unconscious *pseudo-aggressive defense* against deeper repressed *masochistic passivity*. (For a compilation of all three theories, see: this QUARTERLY SUPPLEMENT, II, 1947, pp. 263-303.)

Jackson's book is (despite a few interesting scenes) one of those highly objectionable literary products which indirectly misuse psychiatric findings. Jackson is one of the worst offenders: A previous book, *The Fall of Valor*, centered around a misconception of homosexuality, assuming gratuitously a biological reason for the perversion. There is, by the way, a marked deterioration discernible in Jackson's writings: Some parts of his first book, *Lost Weekend*, were good. Obviously, Jackson has been either from the start a "one-book-author," or he uses—consciously or unconsciously—misconceptions about psychiatry as a substitute for creative writing. All this

could be dismissed as a matter of interest only to literary critics, were it not that, unfortunately, the general public takes books and authors very seriously and accepts their views as authentic. Thus, misconceptions about psychiatry are spread.

The reviewer feels that a protest against Jackson's latest book is particularly in order here, for he feels that the book section of this journal performs a unique function, strangly enough neglected by other psychiatric publications: It watches over the use and misuse of our science by writers. A certain period of our times has been called by a literary critic, fond of colorful phrases, the "century of psychiatry." In view of the misuse of psychiatry by general writers, one must regretfully state that our times seem rather the era of second-hand pseudo-psychiatric misunderstandings.

The Challenge of Parenthood. By RUDOLF DREIKURS. 324 pages. Cloth. Duell, Sloan & Pearce. New York. 1948. Price $3.50.

Dr. Dreikurs has done just as fine a piece of writing in this case as he did when he wrote, two years ago, *The Challenge of Marriage*; the books are companion pieces. Dr. Dreikurs, who organized the first Mental Hygiene Committee, and who is now professor of psychiatry at the Chicago Medical School, has devoted many years to the field of social psychiatry.

The Challenge of Parenthood is a friendly book for it gives one the impression that the author is talking directly to parents and is explaining problems in simple understandable terms. It first describes the intimate situational relationships between the parent and the child. It then describes the most efficient methods of approaching certain conflicting attitudes and the many common mistakes made in training, as well as in understanding, the child. Dr. Dreikurs is not hesitant in telling the parents that they are greater problems for the psychiatrist than are the children.

This book is highly recommended as required reading for the parent and should be in all public libraries.

The Aunt's Story. By PATRICK WHITE. 281 pages. Cloth. The Viking Press. New York. 1948. Price $3.00.

This is a simple yet provocative story of a homely, over-shadowed, sensitive woman. Treated in an imaginative and telling, although somewhat oblique, literary style it takes the reader through her frustrating childhood through flashbacks and really opens with the death of her overwhelming mother. Freed finally by this death, the chief figure seeks self-expression away from her past environment only to find herself hopelessly out of tune with reality. Only when complete delusion triumphs, does she capture absolute serenity of mind.

Road to Normalcy. By HYMAN CHARTOCK. 188 pages. Cloth. Rudolph Field. New York. 1947. Price $2.00.

Dr. Chartock's book is written primarily for the layman in an effort to educate and orient in the field of mental health. He stresses the importance of early recognition of emotional disorders and advises what should be done when early signs of disorders are noted. He explains in clear, simple terms how a "nervous breakdown" occurs and what are the individual's reactions to his illness. His discussion of the various neuroses and mental illnesses is devoid of technical terms and should be easily followed by the layman. Dr. Chartock places special emphasis on the re-adjustment of the veteran. His book is a definite contribution toward better mental health. More and more frequent publications of this sort are needed, whether the subject matter is new or not.

Assessment of Men. By OSS Assessment Staff. 541 pages. Cloth. Rinehart and Co., Inc. New York. 1948. Price $5.00.

"This book is the account of how a number of psychologists and psychiatrists attempted to assess the merits of men and women recruits for the Office of Strategic Services. The undertaking is reported because it represents the first attempt in America to design and carry out selection procedures in conformity with so-called organismic (Gestalt) principles." Chapter I describes in detail the features of the task assigned to the OSS Assessment Staff. Chapters III, IV, V, VII and VIII describe the technical system employed for assessment. Chapter I discusses the principles on which this system was based. Chapters VI and IX reveal the results obtained by the system. Chapter X deals with the conclusions and recommendations made by the OSS Staff.

This book is worthy of reading if for no other reason than to become aware of the tremendously effective methods used by the OSS in its assessment program.

The Rose and the Yew Tree. By MARY WESTMACOTT. 249 pages. Cloth. Rinehart & Company. New York. 1947. Price $2.50.

This absorbing, dramatic but tender novel relates the story, through the pen of a chief character, of a young woman who walked through her brief life in utter realism, surprised by nothing, questioning nothing and receiving destiny in its full impact. Her renunciation of a noble and placid existence and her fatalistic attraction for a man sensual, dynamic and incapable of escaping his inherent sense of inadequacy (which stems from childhood) hold the reader's interest intensely. How love casts out an obsessive fear in the woman and makes possible the sublimation of the man's inherently destructive instincts against a superior society is unfolded, this reviewer feels, beautifully and sensitively in its psychological content.

Practical Physiological Chemistry. 12th edition. By PHILIP B. HAWK, Ph.D., president, and BERNARD L. OSER, Ph.D., director, Food Research Laboratories, Inc., New York; and WILLIAM H. SUMMERSON, Ph.D., associate professor of biochemistry, Cornell University Medical College, New York. 1323 pages with five color plates; 329 illustrations. Cloth. The Blakiston Company. Philadelphia. 1947. Price $10.00.

This book on the chemistry of physiology is direct in presentation, readable, simplified, definitely practical and up to date. This edition includes the present concepts of protein structure, enzyme action and vitamins. One hundred sixty pages are devoted to the analysis and clinical application of the latter. The variability in hemoglobin reports from different laboratories is explained on pages 558 and 559. Numerous illustrations give a concrete idea of the subjects discussed, e. g., the theory of photometric analysis.

The use of bold type for the procedures and fine type for formulae makes it simple to pick out the theoretical and interpretive sections of the book. Excessive and unnecessary tests are excluded so that the actual choice of tests is selective and significant. The chapters dealing with gastric function, respiratory metabolism, blood chemistry, nutrition, deficiency diseases and the physiological availability of the vitamins are of particular value to the clinician. The discussions of antivitamins, antibiotics and metabolic antagonists are stimulating and timely.

Hawks et al. have kept the limits of the book within their appropriate definition of "practical." A valuable 60-page appendix concludes the volume.

The Lesson of Okinawa. By NEWTON DILLAWAY. 34 pages with illustrations. Cloth. The Montrose Press. Wakefield, Mass. 1947. Price $1.25. Paper-covered edition 75 cents.

Dr. Dillaway, who is a well-known child psychologist, bases this short book on the conditions found by American naval doctors during the invasion of Okinawa. They reported extraordinary mental stability among the civilian population in the face of bombardment, battle and conquest.

As is well known, Dr. James Clark Moloney traces the stability of the Okinawans to the love and security they receive from their mothers in infancy. (The organization, the Cornelian Corner, of which Dr. Moloney is a founder, is devoted to promotion of this ideal among Americans.)

Dr. Dillaway presents this doctrine to the layman briefly and concretely. This book is an admirable contribution to greater general understanding of insecurity, one of the greatest of human emotional problems.

The American Language. Supplement II. By H. L. MENCKEN. 890 pages with index. Cloth. Alfred A. Knopf. New York. 1948. Price $7.50.

This book and its two preceding ones should be regarded as indispensable by any American professional writer or editor. The second supplement is to chapters 7 through 11 of *The American Language*, fourth edition. It can, however, be studied as a separate volume as there are explanatory notes covering matters in the original work. The topics are American pronounciation, spelling, common speech, proper names and slang.

This is the English language as it is actually used in this country, not as it is supposed to be. The reviewer would not suggest that scientific writing need, in all cases, follow the colloquial, but he has seen many an article which would have been improved had the author been familiar with common usage. The professional man may also find material of value in Mencken's exhaustive discussions of local dialects. After all, an anamnesis is not of too great use if one does not understand the language of the patient.

Therapy Through Interview. By STANLEY G. LAW, M. D. 313 pages with index. Cloth. McGraw-Hill Book Company, Inc. New York. 1948. Price $4.50.

Interest in shorter methods of psychotherapy seems to be swinging toward the technique of non-directive counseling, as described by Carl R. Rogers, Ph.D. *Therapy Through Interview* is a modification of the non-directive procedures, stressing release of negative attitudes, and placing the technique in a more strictly medical setting. The author discusses the doctor's personality, the limits of therapy and the therapeutic situation, including the "separation phase," and some of the results which may be expected from therapy. The right of the patient to make his own decisions is stressed, and it is pointed out that it takes a mature therapist to allow the patient to come to decisions which may be at variance with his own. The peculiar, and very practical charm of this book lies in the fact that it sets forth its principles by means of a modified interview, or dialogue, technique, covering most of the situations which might be expected to arise in routine psychotherapy. The examples given range from psychosomatic problems to psychopathic states, recording failure as well as success. The non-directive method, as here set forth, is not intended to make the general practitioner into a psychiatrist, but it will enable him to solve many of his treatment problems, including the recognition of some situations which demand the specialist in psychiatry.

The Naked and the Dead. By NORMAN MAILER. 721 pages. Cloth. Rinehart and Company, Inc. New York, Toronto. 1948. Price $4.00.

There is an effortless, almost automatic realism about this novel. The South Pacific veteran is immediately at home among its pages, and it is a safe bet that he will stay at home among them, to the neglect of his work and family, for the day or two that he will do nothing else but seek opportunities to sneak in a few more paragraphs. However, it is not fair to regard this book solely as a war story. Rather, the author has used the war as an opportunity for the presentation of a series of remarkable personality studies, grouped in what might be called a description of the "unconscious" of a platoon in action.

Marriage Counseling Practice. By JOHN F. CUBER, Ph.D. 162 pages. Cloth. Appleton-Century Crofts, Inc. New York. 1948. Price $2.25.

Dr. Cuber, professor of sociology at Ohio State University has written this book not only as a textbook for college courses in marriage counseling, but also to explain to others the fundamentals and the limitations of marriage counseling practice. He has assembled and interpreted available literature; has quoted cases from his own experiences and has written the book in a non-technical manner so that the average reader will understand what he has to say. In doing so, Dr. Cuber has not confined his thinking according to any one school of thought in the methods of psychotherapy. He often repeats that he is not a psychiatrist and that he does not intend to interfere with psychiatric practices. He avoids being specific in diagnostic classifications.

In Part II of the book, the author nicely describes a training program for marriage counselors; points out the limitations and describes current professional needs. His bibliography is especially good.

Readings in the History of Psychology. By WAYNE DENNIS. 587 pages. Cloth. F. S. Crofts and Co. New York. 1948. Price $4.75.

The compiler asserts this is the only set of readings in psychology. He points out that Rand's *The Classical Psychologist* was published in 1912 and obviously does not meet contemporary needs. The present attempt is to reproduce the classics of psychology. Obviously, not all could be included; but perhaps later works will permit a more exhaustive coverage. The present volume contains many excellent articles which are most worthy of reading. Certainly, all students of psychology would do well to include this book in their libraries and add to it as future volumes are published.

Take Off Your Mask. By LUDWIG EIDELBERG, M. D. 231 pages. Cloth. International Universities Press. 1948. Price $3.25.

The author describes a working day of a psychoanalyst, presenting excerpts from eight appointments—a good idea, unfortunately miscarried because of oversimplification. It is a well-known fact that popularization of the analytic procedure in book form is a most difficult task—Scylla being obscurity, Charybdis, simplification. The author's stumbling block is the Charybdic trap. The book is—unfortunately—written in a manner which, like *Lady in the Dark*, conveys the erroneous impression that everybody can be an analyst without much preparatory work. Paradigmatic is a case of frigidity (Case II): The patient's symptom is explained by a repressed warning given to the girl at the time of puberty. What about infantile sexuality? In another hour of the working day (Case III) a theoretical discussion with a would-be patient, a homosexual, is reproduced, which—since no details are given—is neither enlightening, nor demonstrative of the mechanics of treatment.

In a case of suicide (Case VII), the unconscious reasons are not explained. The least objectionable case history is one in which the analyst is silent and the patient recapitulates her treatment (Case VI).

The inadequacy of presentation is visible when the author, in an attempt to be accurate, mentions lighting his cigarettes and changes of his position in his chair. Another annoying difficulty is the air of self-centeredness, permeating the book. There is also a rather curious oversight: The publisher's jacket asserts that the author is a "brilliant writer," and the introduction informs us: "Finally, I had to ask the help of Mr. Sidney Villiers Gerson, who earned my everlasting gratitude by *rewriting* and *editing* this book." (Italics the reviewer's.)

The book is too simple for the psychiatrist, and not informative enough, sometimes misleading, for the layman.

Twentieth Century Speech and Voice Correction. By EMIL FROESCHELS. 321 pages. Cloth. Philosophical Library. New York. 1948. Price $6.00.

Dr. Froeschels offers an excellent book for those who are scientifically or practically interested in speech pathology. He includes the latest developments in speech training and has selected 18 speech specialists to present chapters on specific aspects of speech and voice correction. This book should stimulate interest in the technique of improving and correcting the defects of speech and voice. It is a most worthy contribution to its field.

Nobody's Fool. By CHARLES YALE HARRISON. 300 pages. Cloth. Henry Holt & Co. New York. 1948. Price $3.00.

Charles Yale Harrison whose "durable fame" rests, as attested by *The New York Times,* on his international bestseller *Generals Die in Bed,* has published one of the best satires American literature has produced in recent decades. *Nobody's Fool* is the story of a high class public relations "outfit," capitalizing on the idea of the "common man." The latter is conceived, created, personified, promptly delivered, and misused by the public relations group for shady deals. The result is a biting satire on the misuse of the American success dream.

Good satire is rare, and this alone makes the book worth reading. There are two other merits which are even more exceptional: The amazing fact is to be recorded that not one psychologic error is to be found in the delineation of characters.

Moreover, Harrison's book is primarily a fine study of conscience. In different variations, the *Leitmotif* is repeated: "What is the state of your conscience?" That question, applied to his *dramatis personae,* is admirably solved by Harrison. For the psychiatrist, it is amusing to observe how helpless naïve reviewers prove themselves when confronted with problems of conscience. The problem is either overlooked, or (if the hero reacts in accordance with his inner guilt, as in Harrison's book) it is labeled "trivial" and "banal." "This story ends the way most Gary Cooper films do," complained one reviewer. (In general, reviewers were highly laudatory.) Thus, confusing Hollywood trash with conscience, naïve commentators seems to harbor the precept: "If you aren't a cynic, you don't know the score, or are a liar and hypocrite." That misunderstanding shows the need of teaching reviewers the ABC's of unconscious mechanisms. Psychiatrically, the book is remarkable also for another reason. In an interview which the author granted to an editor of *The New York Times,* he stated that he had been the victim of complete writing-block, lasting for seven years, and that only psychiatric-psychoanalytic treatment cured him.

Nobody's Fool is a rare combination of Aristophanian wit and fine psychologic insight. The latter is encountered in literature only in great and exceptional writers.

Life and Morals. By S. J. HOLMES, Ph.D., L.L.D. 213 pages. Cloth. The Macmillan Co. New York. 1948. Price $3.00.

Dr. Holmes' ideas on ethics seem directly opposed to the view that rules of life are based on supernatural philosophies. He is of the opinion that we should look upon ethics as derived from the processes of human living, experience and social needs. To him, magical development of reasons for

living as we do should be discarded; and scientific thinking should take its place. He believes that it is highly advantageous for us to look upon morals as a natural product. He believes that moral conduct in human society has been the result of adjustments made by society for the general welfare of all persons; that each person within that society must conduct himself properly, else society comes to grief. He elaborates upon the right and wrong of such controversial subjects as divorce, birth control, euthanasia, animal experimentation and the justification for war.

"The reasons why people have developed their peculiar attitude toward the kinds of conduct designated as right or wrong, why they have developed a moral sense, from families to nations, frequently manifest their very different as well as their common characteristics." These reasons are discussed by Dr. Holmes "from the standpoint of biological and social evolution. Among the topics brought within the purview of man's moral duties as a result of his increasing understanding of his world, are man's responsibility for his social order, the evils of poverty, crime and political injustice, the desirability of improving our hereditary endowments, and the vexed problems of group egoism which are giving the world so much trouble at the present time."

Recent Trends in Alcoholism and in Alcohol Consumption. By E. M. JELLINEK, Sc.D. 42 pages. Paper. Hillhouse Press. New Haven. 1947. Price 50 cents.

Dr. Jellinek, director, section of studies on alcohol, Laboratory of Applied Physiology, Yale University, gives in substance the following conclusions:

1. "The per capita consumption of alcoholic beverages . . . rose steadily in the course of World War II, but remained below the levels of the pre-Prohibition years"; but this rise was due to an increase in number of consumers rather than individual consumption. 2. Since 1850 the consumption of distilled liquors has decreased while the consumption of beer has increased markedly. 3. Consumption of alcohol is not affected by any specific liquor control system "but by unwritten social controls." 4. Although there has been an increase in consumption since 1930 the rate of consumption is "still 31% below the rate in 1910." 5. Female alcoholism is by no means "a 'sign of the times.' The female rate of chronic alcoholism was higher in 1910." 6. Alcoholism does not develop at earlier ages now. Its earlier recognition is due to "dissemination of knowledge in relation to alcohol."

This booklet will be of interest to all those studying the problems of alcoholism.

The Psychiatric Study of Jesus. Exposition and Criticism. By ALBERT SCHWEITZER. With foreword by Winfred Overholser. Translation and introduction by Charles R. Joy. 81 pages with index. Cloth. The Beacon Press. Boston. 1948. Price $2.00.

This book was written by Schweitzer in 1913 as a doctoral thesis for his medical degree. It is a refutation of the claims of three scientists, Charles Binet-Sanglé, George de Loosten and William Hirsch, who concluded that Jesus was deranged, in fact diagnosed His particular disease as paranoia. To begin with, Schweitzer points out that every vital human activity must be understood within the conditions of its own age and that we tread on uncertain ground in endeavoring to investigate, in the light of modern psychiatry, the minds of persons from a far distant epoch.

The author maintains that the only mental symptoms to be accepted as historical and to be discussed from the psychiatric point of view are: (1) the high estimate which Jesus had of Himself and (2) the hallucination at the baptism. In regard to the first, the Messianic claims of Jesus, Schweitzer says that the exaggeration of an idea does not in itself justify our considering it the manifestation of psychosis; in regard to the second, he holds that emotionally colored hallucinations are not to be found only in the mentally diseased. They appear also in individuals who are very excitable emotionally but who, nevertheless, can still be considered as falling entirely within the category of healthy people.

Schweitzer feels that the writers he is considering have busied themselves with the "psychopathology" of Jesus without proper study of the historical life of Jesus. Further, out of the material which is historic, a number of acts and utterances of Jesus impress these authors, the writer holds, as pathological because the commentators are too little acquainted with the thought of the time to be able to do justice to it.

Schweitzer puts forward a powerful and convincing argument, and brings a wealth of theological and historical scholarship to the treatise. The book is of particular value in the medical world because of the prominence of religious delusions in psychiatric disorders.

The Ugly Woman. By WILLIAM O'FARRELL. 254 pages. Cloth. Duell, Sloan and Pearce. New York. 1948. Price $2.50.

Why the publishers included this extraordinary psychological novel in the list of their "bloodhound mysteries" may be in itself something of a mystery. There is a mystery element to the story but it is primarily a tale of derangement—of schizophrenia. Whether it is also a case of *folie à deux* or *folie à trois*, whether the swiftness and violence are entirely credible, may raise doubts. This reviewer thinks they are credible and thinks this is one of the best pieces of psychiatric fiction he has seen in a long time.

Phases in the Drinking History of Alcoholics. Analysis of a Survey Conducted by the "Grapevine," Official Organ of Alcoholics Anonymous. By E. M. JELLINEK, Sc.D. 88 pages. Paper. Hillhouse Press. New Haven. 1946. Price $1.00.

The author here analyzes the findings of a survey taken in the form of questionnaires answered by 98 former alcoholics. The questionnaires were used to study the drinking habits, or behaviors, through which each former alcoholic passed and the effects which excessive drinking had on his social relations, on his attitudes and general conduct. No effort was made here to study the environmental and personal backgrounds which might have influenced the development of chronic alcoholism.

This survey is an important one since it gives one increased understanding of the phases through which the alcoholic passes and suggests certain characteristics of the alcoholic which will aid in prognoses and in judging future developments in each case.

I Love My Doctor. By EVELYN BARKINS. 238 pages with illustrations. Cloth. Thomas Y. Crowell Company. New York. 1948. Price $3.00.

This book is the second of its kind by Mrs. Barkins, but deals with events leading up to the first, *The Doctor Has a Baby*. The author is gifted with a lively sense of humor and the ability to transmit it via the written word. She is an attorney-at-law who, as a doctor's wife, finds life interesting and full of unusual twists. She tells of it in a rapidly moving and humorous style. Her account also reveals suspense (the long-awaited first patient) and sarcasm (the emphasis placed on a physician's medical society affiliations when he testifies as a medical witness in court).

It is entertaining, light reading which will be especially enjoyed by physicians and their wives.

Postscript to Wendy. By AMRAM SCHEINFELD. 303 pages. Cloth. Whittlesey House, McGraw-Hill Book Co., Inc. New York. 1948. Price $3.00.

The road to happiness through self-knowledge—by the help of psychoanalytic ideology slowly permeating the psyche of a journalist—is the subject-matter of this searching and well-written book. The form is interesting—letters to a dead sweetheart who had failed to solve the problems of her life and took the way out by suicide. The hero, failing to realize that the dead girl is his unconscious feminine counterpart, is inhibited in assuming normal integrated relationship to the book's heroine, Leta, until he is freed by flashes of psychoanalytic insight, just as Leta is freed by his help from her own "orphan complex." In a mellow mood, for quiet hours of introspection, the book is pleasant and entertaining reading.

Problems of Early Infancy. Edited by Milton J. E. Senn, M. D. 70 pages. Paper. Josiah Macy, Jr. Foundation. New York. Price 75 cents.

This loose-leaf book contains the transactions of the first conference of the Cornelian Corner of Detroit, which was organized in 1942 by a psychiatrist and a pediatrician, but which by now has become a professional group interested in the re-evaluation of the more natural relationship of the mother and her child.

At this first conference, a number of the members were invited to present a discussion of the work which each had been doing in the field of the earliest relationship of parents and their offspring. The principal conclusions presented were that men and women approaching parenthood desire an opportunity to discuss the problems of future parenthood; that failure in effecting breast feeding is due to failure to prepare the mother beforehand, the tendency of the obstetrical staff to discourage breast feeding and the belief that artificial feeding is generally more satisfactory; that the "rooming-in" practice, i. e., where the mother and the newborn remain in the same room, has a great deal of advantage especially psychologically; and that personal psychopathology dates back to maternal attitudes by which the infant suffers—either from lack of gratification, overstimulation or dissociation of sensory experiences.

The German People. By Veight Valentin, M. S., Ph.D. liv and 730 pages. Cloth. Alfred A. Knopf. New York. 1946. Price $6.00.

When an individual becomes entangled with his emotions, errors of judgment may be committed which would otherwise be unthinkable. The historian well knows that during a period of international crisis and conflict, emotions so distort events reflected from the mirror of time that occasionally several generations must elapse before those events can be evaluated with any degree of intelligent impartiality. It is not surprising therefore that during the course of the late war two or three books should have appeared which diagnosed the German people as suffering *en masse* from one or another of the psychoses. For an even longer period the German people have been accused by a group of writers (one hesitates to call them historians) of having actively conspired since the medieval era for world conquest. Readers of Valentin's *The German People* will find it difficult to substantiate either point of view.

Veight Valentin was a native of Frankfurt am Main; he received his degree from the University of Heidelberg, one of the centers of German historical research and a bulwark of liberalism. After the First World War Valentin was appointed to a research position at the Reichsarchiv in Pots-

dam, from which he was ousted in 1933 as "unreliable." He then went to England where he lectured at the University of London. Coming to the United States in 1939, he has continued his researches under the auspices of the Fletcher School of Law and Diplomacy at Tufts College. One might say that for this historian, exile has been a blessing in disguise; it has given him a wider view and a broader perspective, for in speaking of himself and his fellow refugees, he says: "They were forced to re-examine and re-evaluate all their intellectual possessions. Distance and the challenge of a new world made them look at old problems from a fresh perspective and deepened their insight."

The writing of a history of Germany by an exile in such times as these is a difficult task; always there is a suspicion of some sort of bias or of an ax to grind. This may largely account for the fact that *The German People* is something of a modern medieval chronicle of kings, clerics, generals and prophets in a strictly cold and factual presentation of names, dates and events. While there is occasional praise for the contributions or ideas of this or that individual, nowhere is there an attempt at a critical evaluation of the progress of the German people, either social or economic. John Huss, for example, is tried and burned without defense or censure, apology or indignation.

While modern historians do not favor the wholesale dispensation of praise or blame upon this or that individual, they do attempt an analysis of the forces at work and of the pressures brought to bear on a particular society so that some understanding of the relations between cause and effect may be brought out and pointed up. Valentin has neglected this particular task of the historian. More than this, he has neglected to show by what means the early emperors of Germany expanded their power, he has failed adequately to consider the economic backgrounds of the Reformation, and he has avoided an analysis of the effect upon Germany of the industrial revolution and the increase of population. The last two phenomena were closely related to the emergence of socialism and imperialism—dynamic factors in the cause of two great world conflicts. World War I and World War II cannot be discussed understandingly in diplomatic terms alone.

The only attempt at an overview of the German situation is made in the last 10 of over 700 pages. There is found a sharp analysis of six flaws of character which the author believes led to Germany's downfall: (1) "respect for power, for the authority of the uniform, the title, the office, the inside information"; (2) "a chronic distrust of, a skeptical disbelief in, the efficacy of the central and supreme authority . . ."; (3) "a kind of touchiness, narrowmindedness, false pride, and self-righteous ignorance of

the actual forces newly at work in the modern world . . ."; (4) "a sort of petty self-seeking . . . in the national character—envy, touchiness, jealousy, ambition without generosity"; (5) "a deplorable spirit of serfdom—the only possible explanation of the striking successes attained by the Nazi terrorism"; and (6) "a conspicuous lack of balance in the German national character." These flaws, however, seem hardly an adequate explanation of the events of recent years.

It should not be inferred, however, that because of its omissions the book is of little value; quite the contrary. Valentin has collected in one volume, yet outlined in considerable detail, the basic facts of German history and woven them together in one broad colorful panorama. In the words of its publishers, it answers the dire need of a comprehensive and really modern coverage of its subject in a single volume. Truly, the German enigma "must be understood by the rest of the world as the first condition of arranging a tenable *modus vivendi* with a defeated Germany"; this book offers a starting point in unraveling one of the knottiest problems of our time. In the words of Valentin himself: "There is upon Germany something amounting to a blight, a curse. . . . To see, now, a whole nation put in the position of a defendant at the bar is a new thing in history, and it is a deeply moving thing to the hearts of those who perceive a meaning in history."

They Move with the Sun. By DANIEL TAYLOR. 278 pages. Cloth. Farrar, Straus and Company, Inc. New York. 1948. Price $2.75.

Sunflowers move with the sun. So do people. "Daniel Taylor," who is a physician, writes of the boyhood and education of Hank Leher. Hank first saw the sun in a middle western town a generation ago. This is the story of his boyhood in a not-too-friendly environment, of his adolescence and education and of the forces which set him on the road toward practice of psychiatry and psychoanalysis. "Dr. Taylor" intends this volume to be the first of a series on "the development of modern man in the American scene." It is an extremely promising "first." Hank Leher is entirely believable as a boy, a medical student and a young physician.

My Flag Is Down. By JAMES MARESCA. 188 pages. Cloth. E. P. Dutton & Company, Inc. New York. 1948. Price $2.50.

The psychiatrist, wearied of taking case histories, should find some light relief in this collection by a New York taxicab driver.

James Maresca would be at home on a reception service. He has seen stranger people in his cab. Here are sketches of a number of them. Three of the best concern psychiatrists. This book is worth reading for splendid character portraiture and for sheet entertainment besides.

A Treasury of Jewish Folklore. Edited by Nathan Ausubel. 741 pages. Cloth. Crown Publishers. New York. 1948. Price $4.00.

The Jewish people have preserved what is probably the most ancient body of folklore in the western world.

Nathan Ausubel has collected and edited anecdote, tradition and humor stemming from the far-off waters of Babylon and the ghettos of Poland to New York's *nouveaux riches*. Some of the themes are common to all Northern Europe peoples, others to those of the Near East.

The compilation should be as interesting to non-Jews as to Jews, dealing as it does with material which is not only the background of our cultural childhood but which re-appears in the childish fantasy of the individual. The psychologist will take particular interest in the volume's excellent examples of masochistic humor.

The Disruption of American Democracy. By Roy Franklin Nichols. Cloth. Macmillan Co. 1948. Price $7.50.

Dr. Nichols states that this book is "the history of the most dangerous crisis which the Democratic party and the nation ever faced." He interprets the history of the trials the Democrats endured between 1856 and 1861. He attributes the Civil War to the breakdown of the Democratic party in 1861. The loss of leadership to the Republican party by the South brought an organized revolt against submission to the loss of power and social disintegration which the South anticipated. He feels that the Civil War was a political conflict which brought about the destruction of our leaders and disaster to the country.

The Disruption of American Democracy is an outstanding, vivid and most interesting account of one of the greatest American crises. This book should be of particular interest to students of history.

The Inheritance. By Allan Seager. 337 pages. Cloth. Simon and Schuster. New York. 1948. Price $3.50.

As a youngster, Walter Phelps had the astounding experience of seeing his father lick the father of his best friend, after boasting that he could. As a result, Todd Phelps assumed a king-sized proportion in his son's eyes, becoming for him unnaturally heroic. When, upon his death, Walter learned how hated his idealized parent had been, the young man, alone and lonesome, attempted to retaliate against the town in which he lived, completely identifying himself with the brutality and arrogance characteristic of his father. The novel which is extremely well written, although somewhat slow-moving, takes the reader to an unusual conclusion at which the obsessive idea ends and self-realization begins.

Psychobiology and Psychiatry. By WENDELL MUNCIE. 620 pages. Cloth. The C. V. Mosby Co. St. Louis. 1948. Price $9.00.

Psychobiology and Psychiatry is written out of concrete experience and practice. In a great sense this book exemplifies the dictum of William James: "Experience exceeds logic, overflows and surrounds it." The author—who is associate professor of psychiatry at the Johns Hopkins University as well as consultant in psychiatry, U. S. V. A.—combines in a brilliant manner the fields of biology and psychiatry. He stresses the fact that it is the primary task of psychiatry to aid human sufferers.

Dr. Muncie could be called a "pragmatic psychoanalyst," arguing that the effectiveness of medical education must rest finally on its effectiveness in practice. He is a follower of Adolf Meyer. The volume indicates the author's sedulous efforts to test theory and to strip from his service to patients the academic chaff of words, clichés, and hallowed traditions. Throughout the book Dr. Muncie hints at his conviction: that psychiatry will find its proper place in a generally acceptable and accepted obligation to know man—both self and others.

The Stork Didn't Bring You. By LOIS PEMBERTON. Foreword by Dr. William A. Schonfeld. 213 pages. Cloth. Hermitage Press, Inc. New York. 1948. Price $2.75.

As might be inferred from the title, this book brings the "facts of life" to boys and girls in their 'teens. This is done in simplified language, sometimes rather flippantly, but with an undertone of seriousness appropriate to the subject. It is "straight talk," presented cleverly. The psychological aspects of sex are discussed competently, although somewhat inadequately.

Taken as a whole, this book has a rare quality: It can be easily understood by those for whom it was written.

How to Speak Better English. By NORMAN LEWIS. 306 pages with index. Cloth. Thomas Y. Crowell Company. New York. 1948. Price $3.00.

This book can be recommended for the attention of students and of older writers of scientific material who are better grounded in science than in English. Every reader of scientific papers must wish at times that more writers would devote attention to presentation as well as to content.

Lewis' book, although addressed primarily to speakers, should be fully as useful to writers. The author discusses, in extremely simple language, many of the most common errors and their avoidance.

The Parents' Manual. By ANNA W. M. WOLF. With a foreword by Dr. William Healy. Cloth. Simon and Schuster. New York. 1946.

Wise counsel and an easy-reading style make this manual a standout on the long shelf of books in the field. The author confesses, in chapter two, that "there is no way of making any counsel completely foolproof and there is no way to prevent certain parents from finding apparently good reasons for doing what they please." She continues, "They have a right to know and will want to know what performances they may expect at various ages, but they also need to be reminded that there are wide variations in children's growth and that no generalizations can ever take the place of knowledge of an individual child." Such a point of view wins the confidence of the reader, and points to an absence of heavy dogma in what is to follow.

One is not disappointed. This is no handbook on "how to be a successful parent in 10 easy lessons." It is good, solid instruction, with a valid background of psychodynamics. One of the best chapters in the book is called "Psychological Growing Pains." Within it is a section, "How Serious Is a Child's Problem?" Here the author tells parents how to tell a passing problem from a serious one. So many other books leave the parent in a dither over some fancied quirk which, to them, presages mental disorder in their child. Useful, too, is the discussion "Who and What Are the Experts?"

This text is highly recommended for parents, and guidance counselors will find in it valuable material for adaptation to their work with parents.

Mental Health in Modern Society. By THOMAS A. C. RENNIE, M. D., and LUTHER E. WOODWARD, Ph.D. 424 pages. Cloth. The Commonwealth Fund. New York. 1948. Price $4.00.

One who desires to know something of the progress made in the field of treatment and prevention of mental illness during World War II, and the place of professional people in building a healthy society will find this book both informing and stimulating.

The authors have kept abreast of developments in psychiatric treatment and prevention, but are further concerned to relate these insights into various areas of our society to the service of needy humanity. A large part of the book is taken up with what contributions to treatment and to constructive mental health can be made by physicians, social workers, psychologists, clergymen, educators and industrial counselors, as well as by churches, industry, community organizations and government. This is not a book limited to narrow confines, but would be valuable reading for any person interested in how best to apply mental hygiene to his respective field.

Public Opinion and Propaganda. By LEONARD W. DOOB. vii and 424 pages. Cloth. Henry Holt & Co. New York. 1948. Price $4.00.

Well-documented with references, coupled with recommended supplementary readings, Leonard W. Doob's *Public Opinion and Propaganda* seeks to analyze public opinion from the viewpoint of modern social science. Instead of calling public opinion wise or foolish, it makes an effort to identify and explain the segment of human behavior known as public opinion, to describe how people react in social situations, and to assay the importance of public opinion in the modern world.

Professor Doob (of Yale) suggests that propaganda cannot be easily labeled. In his book he focuses attention upon how propaganda functions. The author admits to one major thesis: Public opinion and propaganda, he avers, are intimately related because they both involve phases of human behavior. He therefore advocates an understanding of human behavior, because insight can then be arrived at, especially in relation to propaganda.

Public Opinion and Propaganda necessarily deals with principles, but these are embellished and made understandable by the author's specific illustrations. He draws his analogies and examples from three fields: politics, business and war. Dr. Doob analyzes well the technique of understanding a public opinion poll, even of how to conduct one; of planning or dissecting an advertising campaign; of spraying propaganda upon an enemy or of helping to immunize oneself against enemy propaganda. The book is divided into numerous interesting chapters dealing adequately with social behavior, the nature of public opinion, the mechanics of polling, the nature of propaganda, personality and propaganda, propaganda and action, the media of sight and sound, and the value of analysis.

Managing Your Mind. By S. H. KRAINES, M. D., and E. S. THETFORD. 361 pages. Cloth. The Macmillan Co. New York. 1947. Price $2.75.

This book was originally published in 1943, but there have been seven reprintings since, a fact which, in itself, indicates continued popularity. The authors' objective is to present to the average person methods whereby one may manage one's emotional life in such a way that the greatest happiness can be obtained. The information is presented in ordinary clear language which all readers can understand. The book contains sound common sense, is entertaining as well as informative, and will be very helpful to all persons who are beginners in the study of human nature. The chapter, "A Realistic Philosophy of Life," deserves particular mention, since it is written so that the authors seem to be talking directly to the reader.

CONTRIBUTORS TO THIS ISSUE

PAUL FEDERN, M. D. Dr. Federn, born October 13, 1871, received his medical degree from the University of Vienna in 1895. He was one of the early associates of Freud and was a charter member and acting chairman of the Psychoanalytic Society of Vienna. He was co-founder and co-editor of the German publication, *The Journal of Pseychoanalytic Pedagogy*. He was co-editor of the *International Journal of Psychoanalysis*; and is the author of numerous psychoanalytic reports and scientific articles in German and English. Dr. Federn has been a practising psychoanalyst in New York City since 1938. He is an honorary member of the New York Psychoanalytic Society and is on the teaching staff of the New York Psychoanalytic Institute. Dr. Federn is married and has a son and a daughter.

ROBERT V. SELIGER, M. D. Dr. Seliger is medical director of The Farm for Patients with Alcohol Problems, executive director of the National Committee on Alcohol Hygiene, Inc., and a widely-known writer on alcohol problems. Born in New York City in 1900, he attended Fordham University and the University of Maryland, from which he obtained his medical degree. Formerly assistant visiting psychiatrist at the Johns Hopkins Hospital and instructor in psychiatry at the Johns Hopkins University Medical School, he is now assistant neurologist at the Johns Hopkins Hospital and assistant in neurology at the medical school. He is chief psychiatrist at the Neuropsychiatric Institute at Baltimore and consulting neurologist at the James Lawrence Kernan Hospital and Industrial School of Maryland for Crippled Children. He is president of the Correctional Association, an affiliate of the American Prison Association. He is a fellow of the American Psychiatric Association, and his other associations include the American Association on Mental Deficiency, the American Geriatrics Society, the Association for Research in Nervous and Mental Disease, and the American Society for Research in Psychosomatic Problems, Inc. He is the author of the widely-known *Alcoholics Are Sick People*, published in 1945, *A Guide on Alcoholism* for *Social Workers* the same year, and *Psychiatry for You* in 1946. He is married and has two children. His home is in Ellicott City, Md.

HIRSCH L. SILVERMAN. Professor Silverman is the author of three volumes of philosophy, his latest, *Philosophy: Its Significance in Contemporary Civilization*. He has contributed to many educational and technical journals and periodicals, and is the author of some dozen monographs

on educational philosophy, psychology and sociology. From 1942 to 1946 he served in the army, first as military psychologist and personnel consultant and later as intelligence officer in the Pacific areas and in Japan. In 1946, he became psychologist and assistant chief psychometrist with the Veterans Administration in New Jersey. He studied at the College of the City of New York, the University of Virginia, Yale University, and New York University, where from 1938 to 1940 he held the Hayden Scholarship for a doctorate in educational philosophy. He has lectured and taught at New York University, the College of Social Studies, the University of Hawaii, Long Island University and Mohawk College, Utica, N. Y. Mr. Silverman is a member of the American Philosophical Association, the Institute of International Education and the American Academy of Political and Social Science. He is married and has two children. He is at present living in Newark, N. J.

SAMUEL C. KARLAN, M. D. Dr. Karlan is a graduate of the University and Bellevue Hospital Medical College in 1931. He served for a year at Bellevue Hospital and was on the staff of Dannemora State Hospital for more than eight years. During the war he was chief of the neuropsychiatric service at the Boca Raton Army Air Field Regional Hospital at Boca Raton, Fla. He is now in private practice in Flushing, N. Y. Dr. Karlan is a diplomate of the American Board of Psychiatry and Neurology and a member of the American Psychiatric Association. He is the author of a number of publications dealing principally with psychopathic personalities and prison psychoses. Dr. Karlan is married and has a son and a daughter.

PETER N. PATTI. Mr. Patti, a disabled veteran of World War II, was born in New York City 31 years ago. His art training was at the Leonardo Da Vinci Art School, the New York School of Fine and Applied Arts, the Contemporary Art Center, and the Art Students' League. A teacher of art, Mr. Patti has been art consultant and designer for leading advertising agencies. He is now graphic arts instructor in the Curative Workshop, a part of the physical medicine rehabilitation unit at the New York Regional Office of the Veterans Administration. Since 1946 he has been working with mental patients who have been assigned to art therapy for its supportive role.

ERNST FEDERN. Mr. Federn, born in 1914 in Vienna, had been a law student at the University of Vienna before his arrest in 1938 immediately after the occupation of Austria by the Nazis. Put under arrest by the Gestapo, he was sent to the concentration camp of Dachau and then to Buchenwald as a political and Jewish prisoner. He was a prisoner for six and one-half years until the liberation of the camp by the American army in April 1945. After three years in Brussels, Mr. Federn came to New York where he is now a student at the New York School of Social Work, Columbia University. He is an executive member of KZ—American Association for Former Inmates of Concentration Camps and Other Victims of Nazi Persecution. Mr. Federn is married; he is the son of Dr. Paul Federn of New York City. He has previously published papers based on his concentration camp experiences, dealing with the psychology of the Nazi terror and mental hygiene against war, in French and Flemish in *Synthèses*, Brussels, and *Ontwkkeling*, Antwerp.

ESTELLA M. HUGHES, M. A. Mrs. Hughes is a graduate of the Western Michigan College of Education and of Kalamazoo College, where she took her master's degree in sociology. She was also a graduate psychiatric social worker of the Smith College School for Social Work. She was former eugenics field worker for the National Eugenics Association at Middletown (Conn.) State Hospital and she has been director of the Kalamazoo (Mich.) State Hospital social service department since 1921. For four years she has been field work supervisor of graduating sociology students at Kalamazoo College. She has done research work in Huntington's chorea and alcoholism and has had papers published in the *American Journal of Psychiatry* and the *Journal of Clinical Psychopathology*.

JAMES A. BRUSSEL, M. D. Dr. Brussel, assistant director of Willard State Hospital, was born in New York City in 1905. He is a graduate of the college and of the medical school of the University of Pennsylvania and has done post-graduate work at Columbia and at the New York State Psychiatric Institute. Dr. Brussel served as chief of various neuropsychiatric services in army hospitals from 1940 to 1946, leaving the army with the rank of lieutenant colonel. Dr. Brussel holds diplomas in both neurology and psychiatry from the American Board of Psychiatry and Neurology. He is a fellow (asso.) of the American College of Physicians, a fellow of the American Medical Association and of the New York Academy of Medicine, a member of the American Psychiatric Association and of various other professional organizations. Dr. Brussel has written for both scientific and

popular publications for many years. He is contributing editor on psychiatry of the forthcoming *Collier's Encyclopedia* and is contributing a chapter on the psychiatric aspects of digestive disorders to Kantor's forthcoming *Manual of Gastrointestinal Diseases*. Besides more than two dozen scientific papers on neurology and psychiatry, Dr. Brussel has written much popular prose and poetry, both humorous and in a serious vein. He is also a puzzle constructor and a cartoonist. Dr. Brussel is married. His hobby is music. He plays the organ, piano, saxophone and tympani and was formerly tympanist with the New York Doctors' Orchestral Society.

MARJORIE H. FRANK. Mrs. Frank is director, Service in Veterans Hospitals, American National Red Cross, North Atlantic Area. She is responsible for Red Cross professional personnel in Veterans Administration Hospitals from Maine to Delaware and is in charge of co-ordinating all Red Cross volunteer services for those hospitals. Before taking that position in 1945, she worked for four years as a Red Cross volunteer at Lyons Veterans Administration Hospital, a neuropsychiatric installation. In 1943 Mrs. Frank formed the Union County Mental Hygiene Society in New Jersey and established a mental hygiene clinic for adults and children there. She was president of the society for two years and is still an active board member.

ETHEL B. BELLSMITH. Mrs. Bellsmith, now supervisor of social work at Creedmoor State Hospital, entered the service of that institution in 1923 after two years of work there for the Red Cross with World War I veterans. She assisted in the organization of the Creedmoor social service office and remained there until 1944 when she went on a year's leave of absence to become field director of the Red Cross unit at Mason General Hospital. She organized and directed the Red Cross social service, recreational and volunteer program there. Besides the usual social service activities Mrs. Bellsmith has been active for some years in training social work students from Smith College and from the Buffalo, Fordham and New York schools of social work. She has been active in the affairs of the American Association of Psychiatric Social Workers and is now corresponding secretary of that organization.

ROBERT ALFRED CLARK, M. D. Dr. Clark, born in Boston in 1908, is a graduate of Harvard College and of Harvard Medical School, from which he received his medical degree in 1934. He came in contact with mental hospital work as an undergraduate, serving as a laboratory techni-

cian in Worcester (Mass.) State Hospital in the summers of 1932 and 1933. He later interned in neurology and psychiatry at Boston City Hospital, studied at Boston Psychopathic Hospital and interned in internal medicine at the University Hospitals of Cleveland (Ohio). He served on the staffs of Boston Psychopathic Hospital, Rhode Island State Hospital and Western State Psychiatric Institute and Clinic (Penn.) where he has been clinical director since 1943. Dr. Clark is a diplomate of the National Board of Medical Examiners, a diplomate in psychiatry of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association, a member of the Research Council on Problems of Alcohol and a member of the Continuing Committee, Friends' Conference on the Nature and Laws of our Spiritual Life, as well as a member of other psychiatric and religious organizations. He has taught psychiatry and related subjects at the Harvard Medical School, the University of Pittsburgh Medical School and the Pittsburgh-Xenia Theological Seminary.

ALEX. M. BURGESS, Jr., M. D. Dr. Burgess, a graduate of Harvard Medical School in 1937, was medical director of the American Friends Service Committee from 1942 to 1946. He was chief of the medical service at Colorado State Hospital in 1946 and 1947. He interned in Boston, was a teaching fellow in the department of medicine at Harvard Medical School and later was an instructor in medicine at the University of Colorado Medical School. He holds a certificate from the American Board of Internal Medicine and is at present engaged in the private practice of internal medicine at Providence, R. I. He is an associate member of the American College of Physicians, a member of the American Medical Association, the American Heart Association and other professional groups.

BENJAMIN MALZBERG, M. D. Dr. Malzberg has been director of the New York State Department of Mental Hygiene's bureau of statistics since April 1, 1944. He had been senior statistician and assistant director of the bureau since 1928. He is a graduate of the College of the City of New York and the New York School of Social Work and has A. M. and Ph.D. degrees from Columbia. He also studied on a field service fellowship in sociology at the University of Paris and University College, London. He was statistician of the New York State Board of Charities for five years before coming to the Department of Mental Hygiene. He has written numerous books and scientific articles on the statistical aspects of mental disease.

KARL E. WASMUTH. Karl E. Wasmuth, director of reimbursement of the New York State Department of Mental Hygiene, was engaged in the private practice of law and in research and legal work in various capacities for the State of New York for 15 years before joining the staff of the Department of Mental Hygiene's bureau of reimbursement early in 1945 as assistant chief special agent. He was named director of reimbursement to succeed the late Robert P. Rickards some months later.

Mr. Wasmuth was graduated from the George Washington Law School in 1928 and was admitted to the New York State Bar in 1930.

PAUL O. KOMORA. Paul O. Komora, secretary of the New York State Department of Mental Hygiene, came to the department as assistant secretary in 1942 after 25 years of service with the National Committee for Mental Hygiene. He has been secretary of the department since 1944.

Mr. Komora went to the national committee before the first World War, as secretary to Dr. Frankwood E. Williams, associate medical director. In 1918 he joined the army, serving as a non-commissioned officer as secretary to Col. Thomas W. Salmon, director of neuropsychiatry in the American Expeditionary Force in France. After the war he continued to serve as secretary to Dr. Salmon who was medical director of the National Committee for Mental Hygiene. Later, for many years, he was engaged in editorial and survey work for the committee.

He is the author of numerous articles and reports in the field of mental hygiene.

NEWS AND COMMENT

NEW YORK HAS ADVISORY COUNCIL ON MENTAL HYGIENE

An advisory council to aid in the expansion of New York State Department of Mental Hygiene activities to meet community needs has been named by Commissioner Frederick MacCurdy, M. D. It is headed by Dr. Howard W. Potter, professor of psychiatry at Long Island Medical College. Other psychiatrist members are Dr. Edward A. Sharp and Dr. S. Bernard Wortis, who represents the New York State Medical Society on the advisory council. Dr. J. Lawrence Pool, neurosurgeon; Dr. L. Whittington Gorham, professor of medicine at Albany Medical College; Marian F. McBee, psychiatric social worker and executive secretary of the New York State County Welfare Association; and Judge Henry J. A. Collins of the Nassau County Children's Court complete the advisory group.

The council is to meet monthly with the commissioner. Matters to be considered include: more comprehensive educational efforts to promote the mental health of children; greater provision in general hospitals for mentally ill patients; co-operation with the medical profession generally for more extensive programs for mental care and a more effective state-wide mental hygiene program; and evaluation and formulation of community needs for the Mental Hygiene Department.

RICHARD H. HUTCHINGS MEMORIAL IS PLANNED

A temporary committee composed of Dr. Harry A. Steckel, former director of Syracuse Psychopathic Hospital, Dr. Arthur W. Pense, deputy commissioner of the New York State Department of Mental Hygiene, and Dr. Newton Bigelow, director of Marcy State Hospital and editor of THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT, is in charge of plans for a memorial to the late Richard H. Hutchings, M. D., former superintendent of Utica State Hospital and former editor of THE QUARTERLY and SUPPLEMENT. A series of annual lectures has been suggested, as Dr. Hutchings was greatly interested in teaching. He was on the faculty of Syracuse University Medical School for many years and took an active part in the development of teaching programs for student nurses and social work students. The temporary committee has been in touch with many of Dr. Hutchings' friends and former colleagues but has, of necessity, been unable to cover the entire field. The committee consequently invites any others who are interested in helping to establish this memorial to communicate with the chairman, Dr. Newton Bigelow, editor, THE PSYCHIATRIC QUARTERLY, Utica State Hospital, Utica, N. Y.

DRS. VAN DEMARK AND BLAISDELL RETIRE

Drs. John L. Van DeMark and Russell E. Blaisdell, directors of Rochester and Rockland State Hospitals, have retired after more than 41 and 42 years respectively in the state service. Dr. Van DeMark had been head of the Rochester institution since 1927, and Dr. Blaisdell had headed Rockland since its opening early in 1931.

Dr. Van DeMark, born in 1879, received his medical degree from the University of Buffalo Medical School in 1904; after a general internship, he entered the state service in 1906 and, except for a year of general practice in 1911 and 1912 had remained with the state ever since. He had been at Rochester since 1921 and was named superintendent there in 1927. He is a diplomate of the American Board of Psychiatry and Neurology, a fellow of the American Psychiatric Association and a member of other professional societies. He was married to Dora M. Fuller in 1915. He retired as of January 16, 1948.

Dr. Blaisdell was named superintendent (later director) of Rockland when that hospital was opened. The first children's group was established at Rockland under his administration, the society, WANA originated there, and Rockland was the first state hospital to sponsor Alcoholics Anonymous. Dr. Blaisdell also sponsored pioneer work in the treatment of adolescent boys, in the training of psychologists and in a co-operative program with Union Theological Seminary for psychiatric training of theological students. Dr. Blaisdell's retirement was effective July 1, 1948.

Dr. Kenneth K. Slaght, assistant director, has been named acting director at Rochester to succeed Dr. Van DeMark; and Dr. Blaisdell has been succeeded by Dr. O. Arnold Kilpatrick, associate director, as acting director of Rockland. Other administrative appointments include that of Dr. Francis J. O'Neill, assistant director of Central Islip State Hospital, and Dr. George L. Warner, assistant director of Marcy State Hospital, as acting medical inspectors.

PSYCHIATRIC AIDE CONTEST TO CLOSE NOVEMBER 13

Entries for the National Mental Health Foundation's 1948 award for the "psychiatric aide of the year" will close on November 13. Last year's award was presented to Walter Starnes of Winter Hospital, Topeka, Kan. A New York State hospital attendant, Roy Kimberling of Middletown, was one of the five to receive honorable mention, a $50 cash award and a "certificate of merit."

NATIONAL COMMITTEE MEETS NOVEMBER 3 AND 4

The thirty-eighth annual meeting of the National Committee for Mental Hygiene is being conducted at the Hotel Pennsylvania, New York City, November 3 and 4, 1948. The annual luncheon, at which the Lasker Award in Mental Hygiene is to be presented for outstanding accomplishments in the education of the physician in the psychological aspects of the practice of medicine, is on November 4.

RECEPTION HELD FOR DR. POLLOCK ON 80TH BIRTHDAY

Nearly 100 friends and relatives attended a reception at his home in Middleburgh, N. Y., on September 2, 1948, in honor of the eightieth birthday of Horatio M. Pollock, Ph.D., for many years before his retirement in 1944 director of statistics for the New York State Department of Mental Hygiene. Dr. Pollock was, for a number of years, editor of THE PSYCHIATRIC QUARTERLY and THE PSYCHIATRIC QUARTERLY SUPPLEMENT; he was a world-recognized authority on mental hygiene statistics; and he served as representative of the United States at the Pan-American neuropsychiatric convention in Peru in 1939. Guests at the reception, which was given by Mrs. Pollock, included children and grandchildren and a number of former associates and friends from the Department of Mental Hygiene offices in Albany.

L. J. GREENIER DIES AT ROCKLAND

Lowell J. Greenier, senior business officer of Rockland State Hospital, Orangeburg, N. Y., died of a cerebral hemorrhage on February 9, 1948 at the age of 62. Mr. Greenier had been in the New York State hospital service since 1924, serving at St. Lawrence and Brooklyn State Hospitals, as well as Rockland. He leaves his wife, two daughters and four grandchildren.

DR. TAYLOR NAMED INDUSTRIAL PSYCHIATRY FELLOW

Dr. Graham Taylor of the Allan Memorial Institute of Psychiatry, Montreal, has been selected as the first industrial psychiatry fellow in the School of Industrial and Labor Relations at Cornell University. Dr. Taylor, a native of Canada, and a graduate in medicine of McGill University, served in the Royal Canadian Navy in World War II. The Cornell industrial psychiatry fellowship is believed to be the first of its kind.

ALCOHOL WORLD RESEARCH BULLETIN ISSUED

The first issue of *World Research in Alcoholism,* a bibliography for the professional staffs of Illinois State Hospitals, was issued in May 1948 as a publication of the State of Illinois. Covering current researches as well as selected work over the last 10 years, the bibliography is a monthly publication.

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MARY ADELAIDE NUTTING, NURSE EDUCATION PIONEER, DIES AT 89

Miss Mary Adelaide Nutting, professor emeritus of nursing education at Teachers College, Columbia University, and a pioneer in nursing education, died in her home at Emerson Hall, Columbia, October 3, 1948 at the age of 89. Her death followed a long illness. Miss Nutting, born in Quebec, was educated in private schools there before studying art and music in Boston and Ottawa. She was 30 when she entered the first class of the Johns Hopkins School of Nursing. Miss Nutting went to Teachers College in 1907 and served there actively until she became professor emeritus in 1925. At Johns Hopkins, she had developed the first preparatory course for nurses in this country—a course which gave theoretical and practical instruction instead of beginning training "on the job."

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MORENO CLINIC AND PSYCHODRAMATIC INSTITUTE CONFERENCES ANNOUNCED

The third and fourth national conferences on psychodrama, sociodrama, sociometry and group psychotherapy, sponsored by the Moreno Clinic and the Psychodramatic Institute, will be conducted on November 27 and 28, and on December 26, 27 and 28, 1948 at Beacon, N. Y. The general theme of the conferences is "Training in Human Relations."

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RABBI JOSHUA L. LIEBMAN DIES AT 41

Rabbi Joshua Loth Liebman, author of *Peace of Mind,* nation-wide best seller which was dedicated to his thesis that there was no necessary conflict between religion and psychiatry, died of a heart attack in Boston on June 9, 1948 after a short illness. He was 41 years old. Since the publication of his book two years ago, Dr. Liebman had been one of the best-known figures in the field of mental hygiene. He furthered the cause by radio and lecture as well as writing.

SHORT PSYCHOTHERAPY COURSES ARE GIVEN

A Wednesday evening course in "short-term psychotherapy" is being given the fall and winter of 1948 at the New York Academy of Medicine under the auspices of the Institute for Research in Psychotherapy, Inc. The course, to be conducted by Emil A. Gutheil, M. D., demonstrates modifications of psychoanalysis which are considered capable of shortening treatment. Other courses announced include an introduction to psychotherapy, psychosomatic medicine for the general practitioner, the principles of psychosomatic medicine, and community planning. Lecturers include: Lewis R. Wolberg, M. D., Bela Mittelman, M. D., and Irving Bieber, M. D.

MRS. ABRAHAMER NAMED TO BOARD

Mrs. Cecilia T. Abrahamer, principal of the school of nursing, Willard State Hospital has been appointed to the New York State Board of Nurse Examiners for a term of five years.

DR. HENRY TO DIRECT RESEARCH PROGRAM

Dr. Charles E. Henry has been named to direct an expanded research program in encephalography and allied studies at the Institute of Living, Hartford, Conn. Dr. Henry had been doing electro-encephalographic work at the Institute of Juvenile Research in Chicago and, during World War II, was in charge of a naval electro-encephalographic program at Newport, R. I.

ADVISORY HEALTH COUNCIL APPOINTMENTS MADE

Dr. Leo H. Bartemeier, associate professor of psychiatry at Wayne University College of Medicine, Detroit, and Dr. Carlyle Jacobsen, dean of the Graduate School of the University of Iowa, have been appointed to the National Advisory Mental Health Council to succeed Dr. David Levy and Dr. Edward A. Strecker, whose terms expired June 30, 1948.

DR. BRUSSEL AGAIN LITERARY AWARD WINNER

For the third year in succession, ever since the contest was inaugurated, Dr. James A. Brussel, assistant director of Willard State Hospital, has won both the first and second "Class A" prizes in the annual national contest of the American Physicians Literary Guild. The 1948 prizes were for a satirical opera and a short mystery story.

PSYCHIATRY FOR GENERAL PRACTITIONERS

An all-day course in psychiatry for general practitioners will be offered by the Medical School of the University of California at the Medical Center, San Francisco, from January 31 through February 4, 1949. The course is intended to convey some knowledge of the major psychoses, with discussions of what the general practitioner should do when he encounters them; to give the general concept and treatment of the psychoneuroses; to consider integration of psychiatry with other medical fields and to take up some topics in the field of psychosomatic medicine.

WILLIAM H. HECOX, 35 YEARS BOARD MEMBER, DIES

William H. Hecox, for 35 years a member of the Board of Visitors of Binghamton State Hospital, died in Binghamton at the age of 86 on February 6, 1948. His interest in the institution went back to his young manhood; he had attended 56 consecutive annual field days at the hospital.

NEW CHILD GUIDANCE CLINIC FOUNDED

A new child guidance clinic for the Oranges and Maplewood, N. J., to supplement the Essex County Child Guidance Clinic which was directed by the late Dr. James S. Plant, is being opened this fall. It is supported by joint action of the municipal governments in the territory concerned; a staff is sought to include a child psychiatrist, clinical psychologist and two psychiatric social workers.

THE PSYCHIATRIC QUARTERLY SUPPLEMENT

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